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ABSTRACT

These materials for a classroom or individualized learning setting comprise a curriculum for parenting education for school-age parents. The student textbook covers these topics: pregnant teenager's self-image, questions, and concerns; reproductive cycle and fetal development; prenatal changes and care; preparation for labor and delivery; postpartal care and concerns of the new mother; decision-making process; family planning concepts and methods; and parenting concepts and concerns. Working with Childbearing Adolescents, a guide for use with the text, assists professionals from varied disciplines in improving their effectiveness in working with pregnant teenagers and teenage parents. A chapter on developing a program for teenage parents is provided. Contents include adolescent development process, teenage sexuality, implications of adolescent childbearing, strategies for intervention, teenagers as parents, maternal-infant bonding, complete lesson plans to accompany the text, bibliographical resources, updated film lists, sources of free and inexpensive materials, and reproducible charts and diagrams. The other five booklets in this package are (1) a teacher's manual for the textbook, which outlines objectives, content, suggested methods, and resource materials; (2) student study guide for the textbook; (3) Breastfeeding: Something Special for Mother and Baby; (4) exercise booklet; and (5) statistical summary (1977-78) of New Futures School. (YLB)

TEENAGE PREGNANCY: A NEW BEGINNING

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Dedication . . .

This book is lovingly dedicated to our students, who also became our friends and our teachers.

With appreciation to
John B. Coppes, M.D.
James Hutchison, M.D.
Linda Essay Bunnell, M.A.
Board and Staff of New Futures School

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ESPECIALLY FOR YOU

This book has been written especially for you, the teenager who is expecting a baby. For the past seven years, we have worked as teachers in a special school for pregnant teens. During this time, we have been close to hundreds of young women. We have shared their hopes and fears. Whenever we could, we've answered their questions. And they have answered ours. Our students have helped us grow and learn. In return, we have watched them growing from girls to women. We have seen them do well with their pregnancies and become the kind of people they want to be. This book is a result of those years of sharing.

During your pregnancy, you will find yourself growing in many ways. You will wonder about the many changes happening in your life. Like most pregnant women, you will want to know about the changes in your body, how the baby develops, and how to take care of yourself during pregnancy. You will also wonder what childbirth will be like and want to get ready for it.

You will be thinking about becoming a parent. Right now, it may be hard for you to think of yourself as a mother. Yet, while you are carrying this baby inside you, you are already a parent. You are responsible for the baby's growth and care. Being a parent begins with the way you take care of yourself while you are pregnant. It also begins with the way you think about yourself and about the baby growing inside you.

There will be many decisions for you to make during this time. You will decide about keeping the baby or releasing it for adoption. There will be other important decisions to make about school, family, marriage, and your future. So many things to think about! So many choices to make!

This book is about all of these things. We hope the information we have given will answer many of your questions and help you make decisions. We wish you well during this time. We hope that your pregnancy will go well and that your baby will be healthy and normal. Most of all, we hope you will be happy with the choices you make for your lives.

We wish you happiness,

Catherine

Linda

This book is about two people — you and your baby. You will notice that we always call the baby "him". We realize that many of you will give birth to girls. But to help keep things clear, "she" will refer to the mother and "he" will mean the baby.

TEENAGERS TALK ABOUT THEIR PREGNANCIES

1

We have learned to love and respect our students. So we have gone to them for help with writing this book. Throughout its pages, we have used their own words. Many of their thoughts and feelings will be a lot like your own. You are not alone. In this country, over a million teenagers become pregnant each year.

"When I found out I was pregnant, I was really shocked! I felt like the world was going to end!"

"I felt scared and worried. I didn't know what I would do and how I could handle being sixteen and pregnant. I was afraid it would ruin my whole life."

"I felt both happy and sad at the same time. I knew this would change my whole life. Now I was on my own, and I had to grow up. I was going to be a parent."

Shocked, scared, confused, alone, afraid — yet, happy — these are the feelings many teenage girls have when they first find out they're pregnant. Since most teenagers don't expect to become pregnant, many young women are not prepared for this news.

"I never really associated sex with pregnancy. Sex was just something that my boyfriend liked, and pregnancy was something that happened to somebody else. Oh, sure, I knew that was the way girls got pregnant. I just didn't associate it with me."

"I never really thought this would happen to me!"

If you felt this way, you are not alone. Sex is a new experience for teenagers. In your mind, sex probably didn't have much to do with being pregnant. As one teen said . . . "Lots of people try it; I just got caught!"

With pregnancy comes change.

"Being pregnant has changed my life a whole lot. I can no longer be a girl with no responsibilities and no plans for the future. I feel like I've gotten a lot more mature in the last few months."

"You change. It comes with facing reality. A dream becomes a fact — a fact you have to face. You realize you're not the same person any more."

"It changed my life, mostly because it made me settle down and grow up a lot faster than I had planned!"

During your pregnancy, you will find you are constantly changing. You may feel uneasy at first; but as time goes on, you will become more used to the idea of being pregnant. You are growing from girl to woman and are more concerned now about your future. You are responsible not only for your own life, but for the life growing inside you.

"It's not just me any more. There's a baby inside me depending on me for everything."

"I knew there was now a baby being formed, and I couldn't think of doing anything to hurt it."

Taking care of your body means taking care of your baby. You will want to learn all you can to make sure the baby is born healthy and normal.

MOODS

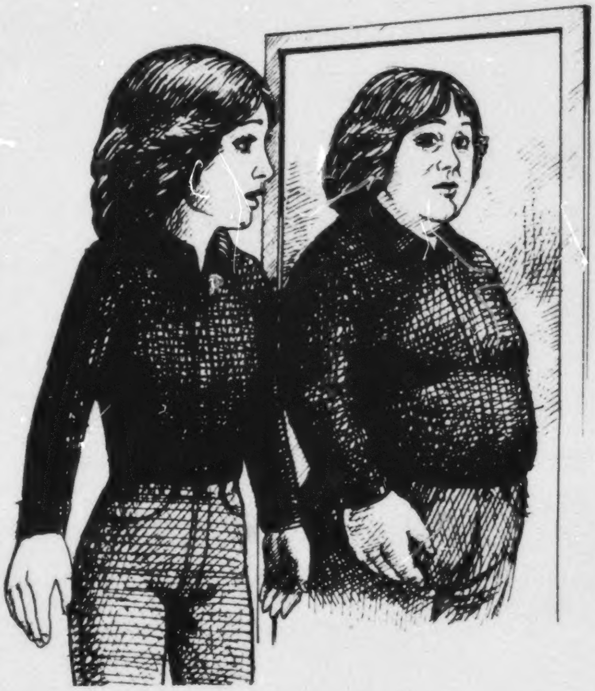
"Pregnancy really isn't what I'd expected. It's easy to get tired and depressed. I sort of thought that when a girl was pregnant, she just got big and never felt anything. I found out I was wrong."

"Up and down constantly — one second, happy; the next, depressed."

Every pregnant woman has mood swings. One minute you are happy; the next you are in tears — often for no reason. These ups and downs happen to everyone. They are caused by the many changes that are happening to you. At times, it may be hard for the people around you to figure you out — especially men.

BODY IMAGE

"At first I felt ashamed of my body. For such a long time I kept trying to hide my big stomach. Any more, I don't try to hide my pregnancy. I'm not ashamed of it. On the other hand, I'm not proud of it either."



"I feel big and bloated, almost like I swallowed a balloon, and it gets bigger every time I breathe. My bust has really grown, too. I really feel self-conscious. Sometimes I like to advertise my stomach, make people notice I'm pregnant. Most of the time it kinda bugs me to be big."

"I felt wonderful because I knew that my baby was growing. To me, my stomach looked beautiful."

"Now that I'm pregnant, my body really doesn't bother me. There's a baby growing inside of me and that makes it all worth it."

You may have mixed feelings about your body. At times you will feel proud to be pregnant. There are other times when you feel big and fat. Many people think that a woman is beautiful during this time. If you take good care of your body, it will soon be back to its normal size.

DECISIONS

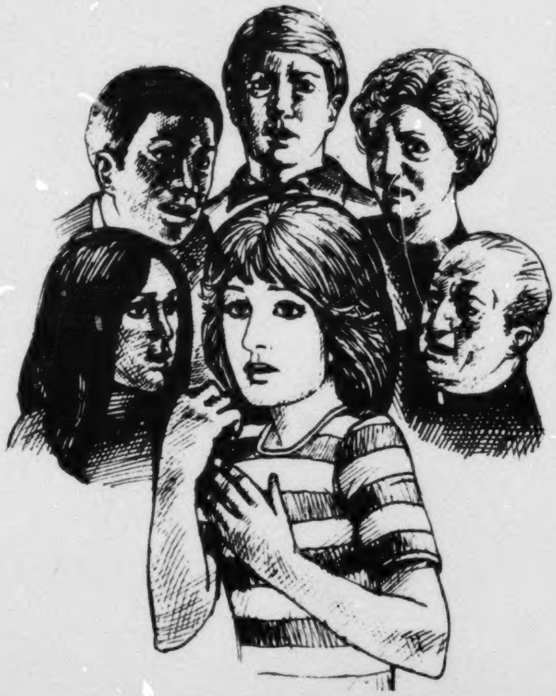
"The hardest part of being pregnant is all the decisions I have to make. I had always depended on my mom to make my decisions for me. Now, so much is up to me."

As a pregnant teen, you will have to make all sorts of decisions for your life. Some of these choices will be hard to make. One of the hardest may be whether or not to keep the baby. You will make other important decisions about your boyfriend, your family, school, and even your health. Learning to make and live with decisions is a part of becoming a woman. You may want help with your choices, but the final answers are up to you. You are the one who will have to live with your choices. Take time to decide and choose carefully.

ADVICE GIVERS

"I get so confused because everyone tries to tell me what to do."

"I can take being pregnant, but not the hassles I get because of my decision."



You have many of the responsibilities of a woman, but some people still want to treat you like a child. People mean well and really want to help. So they all give you suggestions about what they think you should do. All this advice can be very confusing.

You can listen to what they have to say. Thank them for their advice. Accept it as a gift. Then, you have the choice of what to do with the advice. If it makes sense to you, you can follow it. If you're not sure, talk it over with someone you trust. If you disagree, you can choose not to follow it. Tell others what *you* want and how *you* feel. Do what seems best in your situation.

You will want other people to respect the decisions that you make. It is also important that you respect theirs. *No one decision is right for everyone!*

"I expected being pregnant at my age would be just terrible. I have realized now, though, that there are many other girls in my situation, and that really helps me. I think the most important thing this has done for me is I've grown up so much. I've been away from my parents, and I've had many decisions to make on my own. If I can make it through this, I can make it through anything . . ."

We believe that you can become the person you want to be and make it in life. But it's not enough for us to believe in you. *You need to believe in yourself.*

You have a choice about this:

You can put yourself down for this pregnancy. If you do, you can expect to be unhappy . . .

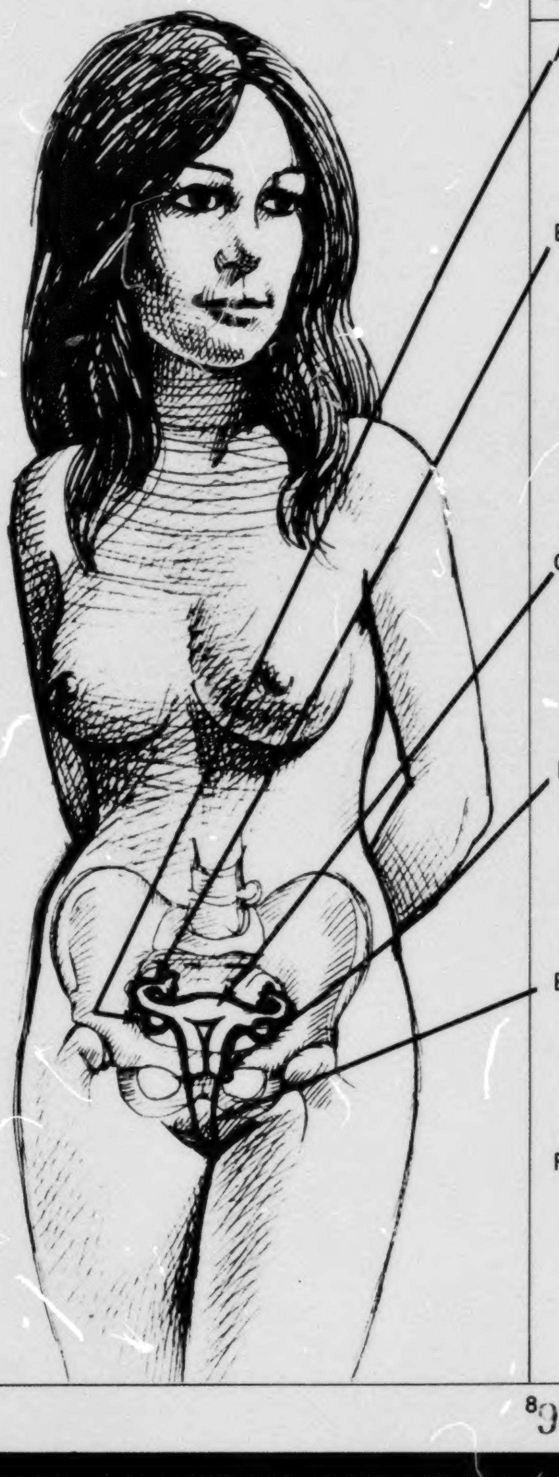
OR

You can accept it as a chance to grow. If you do, you can come out knowing yourself better and feeling more confident than before.

The choice is yours!

UNDERSTANDING HUMAN REPRODUCTION 2

Becoming a teenager brings about a lot of changes in a young woman's life. These early teen years are often confusing and hard. Between the ages of 11 and 14, your body suddenly began to change. Your breasts began to grow, and you started having menstrual periods. You began to look and feel more like a young woman. You may have wondered about these changes. Maybe no one has explained them to you. You have a right to understand how your body works. This information will also help you to understand your pregnancy better and to prepare for labor and delivery.



Female Anatomy (The Parts of Your Body)

A. OVARY ("eggery") - The two ovaries are connected to the uterus by ligaments. Each ovary is the size and shape of an almond. These small organs produce egg cells (ova) and hormones.

B. FALLOPIAN TUBE (egg duct) - These tubes are connected to the upper part of the uterus and curve above the ovaries. They are about four inches long and the size of a clothesline rope. The tubes are not connected to the ovaries. Tiny waving fingers at the end of the tube catch the egg and draw it inside. The egg moves along the tube for about two to four days. Here, the female egg and male sperm can meet.

C. UTERUS (womb) - The uterus is about the size and shape of a small pear. It has a thick muscular wall and is hollow inside. This small organ can stretch large enough to hold a growing baby. Yet, it goes back to its normal size after the baby is born!

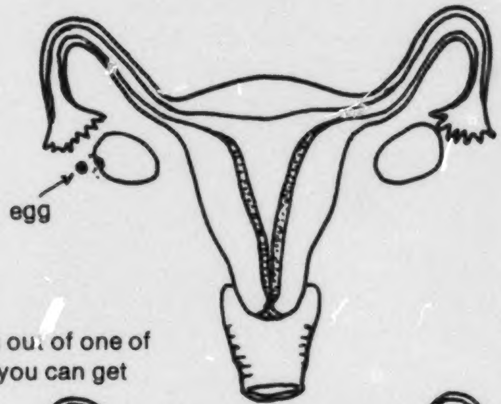
D. CERVIX (mouth of the womb) - The cervix is the lower part of the uterus. It extends about one and one-half inches into the vagina. In the center of the cervix is a tiny passageway opening into the vagina. It will open up during labor for the birth of the baby.

E. VAGINA (birth canal) - The vagina is a muscular tube that leads from the uterus to the outside of the body. It is about four to five inches long. It can open up to allow the entry of a penis or the exit of a baby.

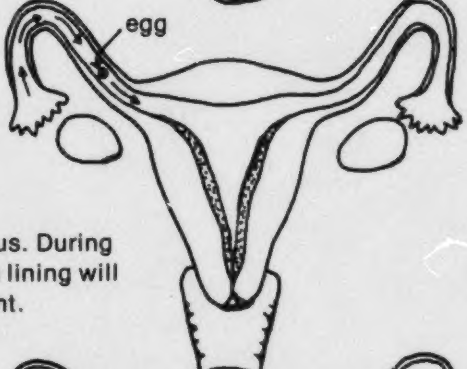
F. OVUM (egg) - The ovum is the female reproductive cell that can join with the sperm (male seed) to start a new life. Usually only one egg is released from the ovary each month.

Female Reproductive Cycle
(How Your Body Works)

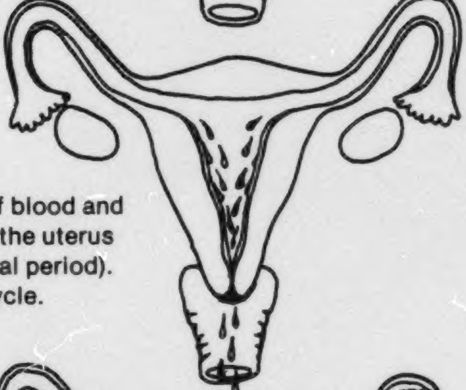
A cycle is a series of events that are repeated regularly. The reproductive years begin when a girl has her first menstrual period. The menstrual cycle will repeat itself until the woman reaches menopause (change of life). This cycle is about 28 days in length, but this can vary from person to person. Many young teenagers have cycles that are more than or less than 28 days (irregular periods). The menstrual cycle is also known as the reproductive cycle. The menstrual period is the first part of the cycle.



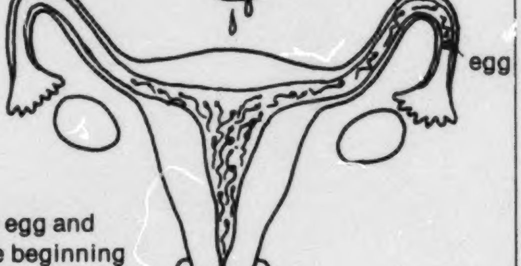
About 14 days before the menstrual period starts, an egg pops out of one of the ovaries (OVULATION). This is the time of the month when you can get pregnant.



The egg is drawn into the tube and moves slowly toward the uterus. During this time, the uterus is building a lining of blood and tissue. This lining will be used as a nest for the growing baby if the woman gets pregnant.

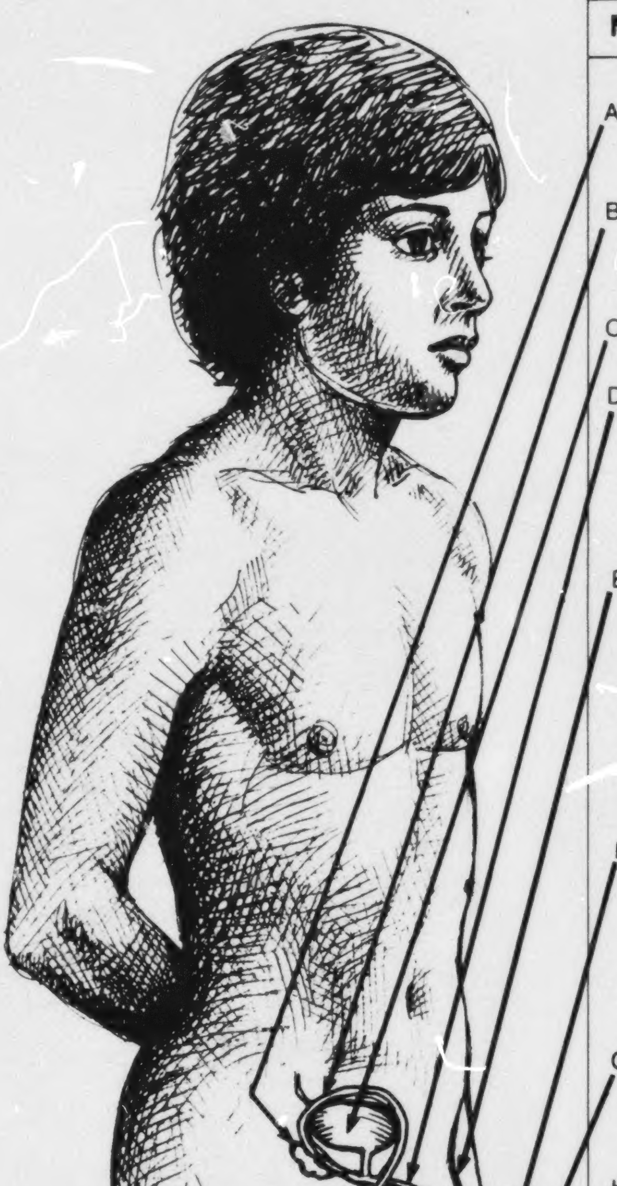


If the egg is *not* fertilized, it will dissolve. Therefore, the lining of blood and tissue is not needed. In about 14 days it will begin to flow out of the uterus through the vagina. This is known as MENSTRUATION (menstrual period). The first day of the menstrual period is the beginning of a new cycle.



If the woman has sex around the time the egg is in the tube, the egg and one sperm can join together. This is called FERTILIZATION, the beginning of a new life. The fertilized egg moves down the tube and buries itself in the lining of the uterus.

Young men mature later in their teens than girls. Often they don't begin to notice changes in their bodies until they are between 13 and 15. Around this time, their voices get lower and hair begins to grow on their bodies. About this same time, the testicles ("balls," "nuts") begin to make sperm cells that can fertilize an egg. They may also begin to have NOCTURNAL EMISSIONS ("wet dreams") during their sleep. This is the body's way of getting rid of excess sperm and is nothing to worry about. Boys also get ERECTIONS, or hardening of the penis. Erections can be caused by many things, such as thinking about sex, looking at girls, or rubbing the penis. Sometimes it seems to happen for no reason at all. An erection makes it possible for the penis to enter a woman's vagina and deposit sperm.



Male Anatomy (The Parts of **His** Body)

A. SEMINAL VESICLES - These are two small pouches in which the semen is stored.

B. VAS DEFERENS - They are two tubes about eighteen inches long which carry sperm from the testicles to the urethra.

C. BLADDER - The organ where urine is stored.

D. URETHRA - This small tube runs through the center of the penis. It serves two functions for the male: (1) carrying urine from the bladder, and (2) carrying sperm cells when he EJACULATES ("comes").

E. PENIS - The penis is the male organ for urination (peeing) and sexual intercourse (making love). The size of the penis varies a great deal from one man to another. The penis is made of spongelike tissue. When the man becomes sexually excited, this tissue fills with blood and the penis gets hard. This is called an ERECTION ("hard-on").

F. TESTICLES (testes, "huevos", "balls" or "nuts") - The testicles are two small, egg-shaped glands which make sperm and male hormones. They are located in a bag outside the body because the temperature inside the body is too warm for the sperm to live.

G. SCROTUM - This is a bag made of skin which holds the testicles and keeps them at the right temperature.

H. SPERM (seed) - The sperm is the male reproductive cell that can join with the female cell to form a new life. Sperm are carried in a thick, white fluid called SEMEN. In the semen, the sperm move by lashing their tails back and forth. Each time a man "comes", he ejaculates 200-500 million sperm! *It takes only one to fertilize the egg.*

Sexual Feelings

This, then, is how the male and female reproductive systems work. But it's just as important to think about and understand sexual feelings. Many teens are confused about their sexual feelings and how to handle them. Getting comfortable with these feelings is a life-long process. Some people will say that sexual intercourse ("making love", "having sex", "getting it on", etc., etc.) outside of marriage is wrong. Others will disagree and tell you to go ahead. This puts a lot of pressure on you to decide. But only you can make that choice.

All of us have sexual feelings. They begin when we're born and are with us until we die. They are normal and natural. What to do with these feelings is up to each one of us. Your body is your own - you have the choice of whether or not you will have intercourse. When making this choice, it is important that you consider the effect it will have on your life and on the life of your partner. Are there other people you should think about also?

“Sometimes I don't think sex is what it should be, but that's probably my own fault for watching so many TV shows. They always make it look so romantic and it always happens so perfectly. Sex is something special, but sometimes it's not everything it's built up to be.”

“I think sex and values can work in harmony. If you really love each other and are responsible . . . you can handle it. I'm not sure what I did was too right, because I wasn't ready and I knew it!”

“I guess sex is what I expected it to be. I wouldn't have sex with someone unless I really loved him, and when I did, it was beautiful!”

“Sex isn't what I expected it to be. My first experience with sex wasn't a very good one. I didn't want to go all the way, but I wanted to know what it would be like. I think that sex isn't what I expected it to be because of my first experience.”

KEEP OFF
ROOF — NO
RUNNING
BOARD

It is important that our actions and our beliefs match. When we follow our beliefs, we can feel good about ourselves. When we don't, it can make us very uncomfortable. The best way to avoid problems is to decide what it is that you believe and then follow those beliefs.

First experiences with sex are sometimes disappointing. When this happens, teens may be afraid that there is something wrong with them. Most often, the real problem is that they feel guilty about what they did. They weren't ready and they knew it!

“*With me and my boyfriend, we are very open about sex. I think you feel more at ease when you can talk to your partner. Because if you do something that you don't want to do, you're not going to enjoy it. I think it is a very good idea to be as open as you can about everything with your partner.*”

“*I get embarrassed when I talk to a guy about sex, unless I know the guy real well.*”

“*I really feel good about talking about sex with my partner because if I'm going to have sex I want to have fun, and I don't want to get hurt!*”

“*Me and my boyfriend never really talked about sex, except when he would ask me if I wanted to. We also never talked about birth control. Now I really wish we would have, cause talking about things really helps!*”

It may be hard to talk to your partner about your sexual feelings. Yet, most teens agree that this is very important. You can not expect another person to understand what is going on unless you tell him!

“*Everyone is different. I guess they have to learn to control their feelings by themselves. It's best not to get involved sexually with anyone unless they're mature enough to handle the consequences — whatever they turn out to be.*”

“*I feel that both the girl and the guy have the same responsibilities, but sometimes the girl can get pushed into something she really doesn't want.*”

“*Both partners need to be responsible. It might be hard for a girl to take care of herself if she doesn't know how to say "no" or if she doesn't know how to say what she feels.*”

Most people today agree that handling sexual feelings should be up to both partners. That's fine, as long as your partner is willing to share the responsibility. If he isn't, it's up to you to take care of yourself. Remember, your body is your own. You have a right to decide how you want to handle the situation. You have a right to say NO!

“*I think a girl has the right to decide whether or not to make love. It may be up to her to stop things before they go too far.*”

“*Well, really, if the girl wants to have sex, it's her business, but I think she should at least use some kind of birth control.*”

“*I wasn't too concerned about using birth control. It all seemed like too much trouble. Of course I was worried about getting pregnant, but I never really thought I would.*”

“*If a boy isn't her steady boyfriend, I really don't think a girl should have a sexual relationship. And if he is, I think she should use some method of birth control.*”

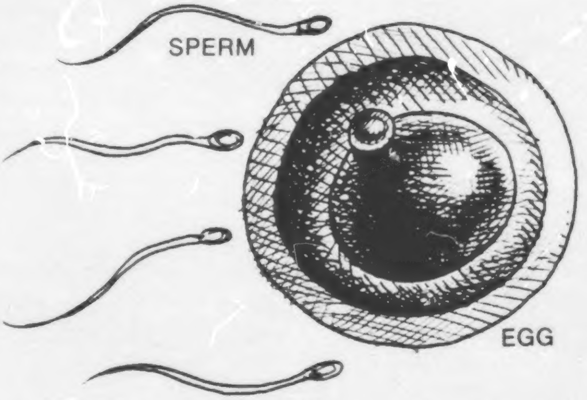
Most pregnant teens say that whether or not a girl has sex is her business. They agree, though, that unless she is ready for a pregnancy, it's best that she use some kind of birth control. If you decide to be sexually active, you are responsible for what happens!

TWO STORIES AT ONCE

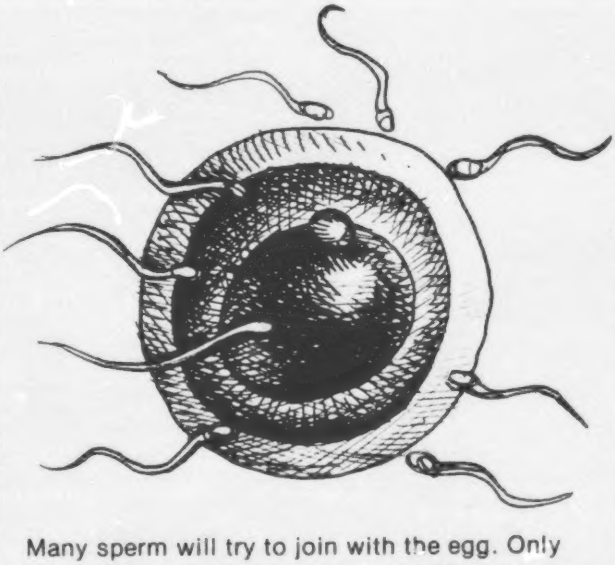
3

There are two stories going on at one time — yours and the baby's. As you watch your own body grow and change, it may be hard to imagine that another human being is growing inside you. Yet, the first three months of the developing baby's growth are some of the most important he'll ever go through. By the end of the third month, his body will be completely formed! And you may not even know for sure that you're pregnant!

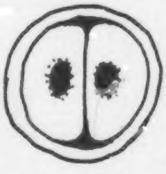
The first three months of a new life



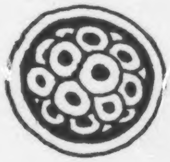
The new life begins when the sperm meets the egg. The mother's egg is smaller than the dot at the end of this sentence. The sperm is even smaller. It is the sperm that will determine if the baby will be a girl or a boy.



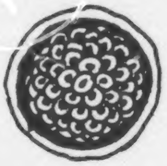
Many sperm will try to join with the egg. Only one sperm will reach the center of the egg. When the sperm joins with the egg, the two cells become one. This is called FERTILIZATION. It will take about 266 days for the baby to finish growing and be ready to be born.



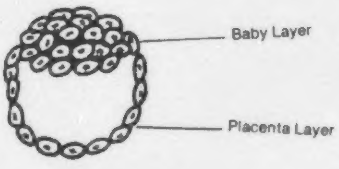
Thirty hours after fertilization, the cell divides into two cells that are exactly alike. This dividing begins while it is still in the Fallopian tube.



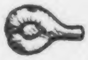
The two cells soon divide into four, then eight, sixteen, thirty-two, and so on.



The cells keep dividing while they move down the tube to the uterus. It takes about 5 days for the 100-150 cells to get there. Then the group of cells will bury into the lining of the uterus. This is called IMPLANTATION.



The cells divide into two different layers. One layer will form the PLACENTA (afterbirth) and UMBILICUS (cord). The other layer will become the baby.



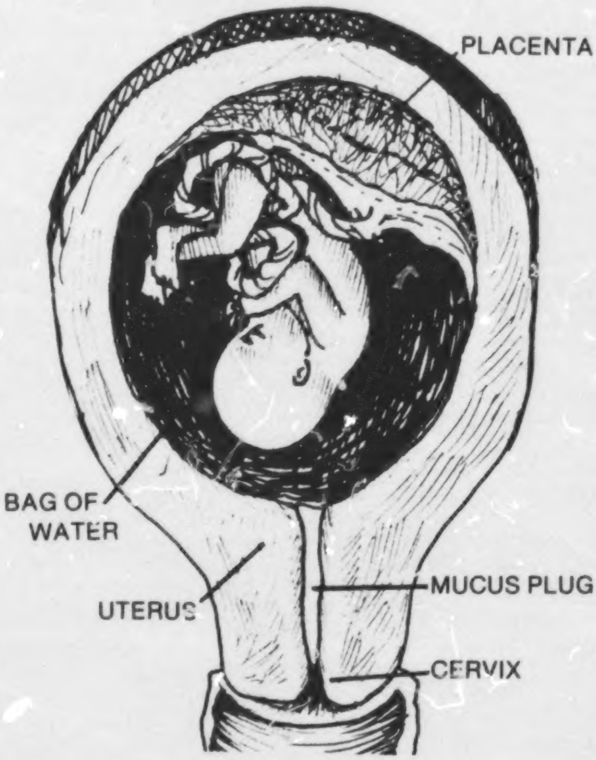
TWO WEEKS: There are thousands of cells. The baby's brain has begun to form. He is called an EMBRYO, which means "young one".

FOUR WEEKS: The embryo is the size of a pea. The arms and legs are beginning to bud. The tiny heart has begun to beat. The brain is so large that the head bends forward. The spine is growing so fast that the embryo looks like he has a tail. He still does not look like a baby.

SIX WEEKS: He could fit into a walnut shell and weighs less than a book of matches! Yet, the eyes and ears can be seen. The bones have begun to form.

EIGHT WEEKS: The embryo now has tiny arms and hands. His fingers already have fingerprints. His legs have knees and ankles and feet with tiny toes. The arms and hands develop faster than the legs and feet because they are closer to his brain. The eyelids are sealed shut to protect his eyes while they are forming.

TWELVE WEEKS: The embryo now has a new name. He is called a FETUS, which means "offspring". All of his inside organs are formed, and he looks like a real baby. He is almost three inches long (7.6 cm) and weighs one ounce (28.35 gm). You can now tell if this tiny baby is a girl or a boy. The baby's teeth have begun to form in the jaw. He has nails on his fingers and toes.



The PLACENTA forms during the first three months. This small flat organ looks like a pancake and is attached to the wall of the uterus. The umbilical cord grows out of the placenta and connects to the baby at his NAVEL (belly button). The placenta and cord are a lifeline for the growing baby. Blood flows from the baby through the cord and into the placenta. Here it leaves the baby's waste products and picks up food and oxygen. The mother's blood and baby's blood are separated by a thin layer of cells, called a membrane. Between the wall of the uterus and the baby is a bag of water (AMNIOTIC SAC). The water is called the AMNIOTIC FLUID. This water protects the baby from bumps and falls and gives him freedom to move around. The water in the bag is cleaned about eight times each day. No one knows for sure how this happens. A mucus plug blocks the opening in the cervix to protect the baby.

FIRST TRIMESTER
The first three months of your pregnancy

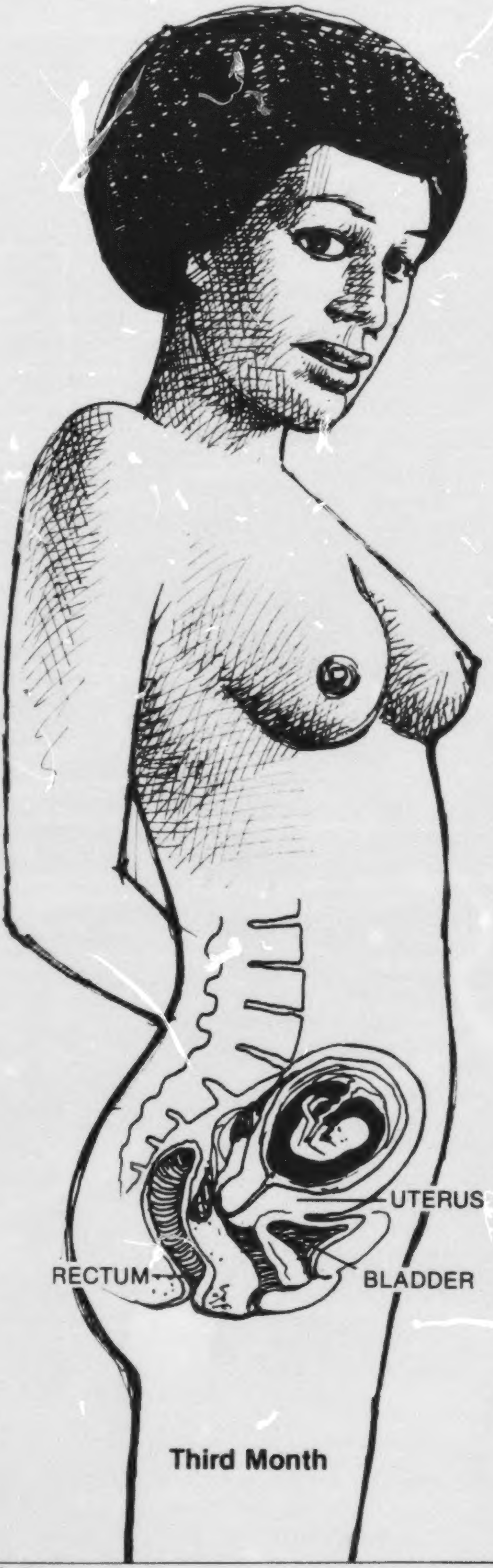
At first, you will not know that you are pregnant. Yet, another story is beginning for you. You may first think that you are pregnant when you miss your period. Menstruation stops because the blood and tissue will be needed as a "nest" for the growing baby, and because no more eggs are released from the ovary.

The early signs of pregnancy are not the same for all women. Very early, you may notice a change in your breasts. The nipples may seem a little bigger and darker, and they may feel a little sore. Some women may have an upset stomach during the first three months, often called "morning sickness". Others notice that they feel tired and sleepy most of the time. Because the uterus is beginning to get bigger, it crowds the bladder. You may notice that you have to go to the bathroom (urinate, "pee") more often.

Since the baby is still quite small, the mother should not gain much weight during these first few weeks.

The first trimester of pregnancy is often called the time of adjustment. You are adjusting to the idea of being pregnant while your body is adjusting to the changes caused by pregnancy. You may find that you get upset easily and may cry for no real reason. Little things that didn't upset you before may all of a sudden make you touchy or angry. You may feel depressed and "blue". You may not even believe you really are pregnant. These are normal feelings caused by the changes in your body and probably won't last long. Even if you want to be pregnant, you may have these feelings. If you don't want to be pregnant, then it takes time to adjust to the idea. Explain to those around you (your family, husband, or boyfriend) that these changes are normal. Ask them to be understanding and patient with you until you are feeling more like your old self. Remember that they have to adjust to your pregnancy, too, and may need your love and understanding.

Many people believe that what a pregnant woman sees will mark the child's body. Don't be afraid! The sight of an ugly animal *won't* make the baby look that way.



Third Month

SECOND TRIMESTER
The fourth, fifth and sixth months

By the second trimester, your body will have adjusted to the early changes of pregnancy. You will be feeling much better and should have more energy.

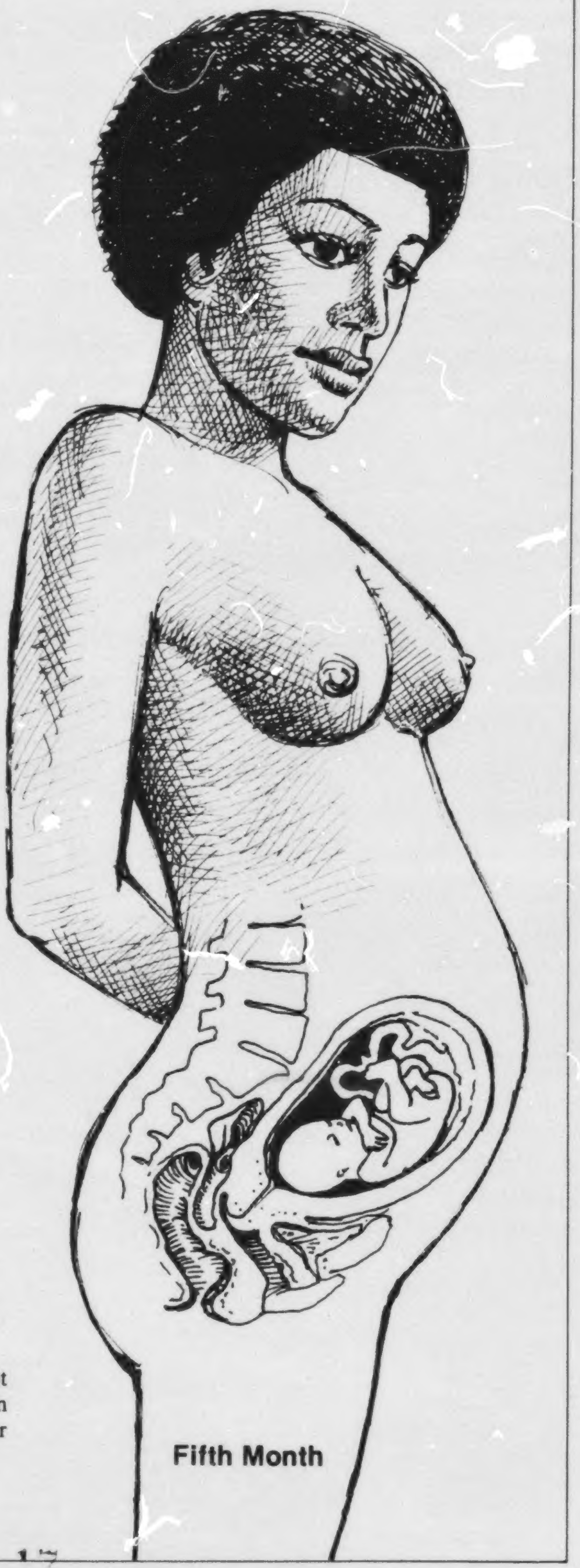
You may find that you are in better moods and are easier to get along with. You may think more about the baby now as he becomes more real to you. The second trimester is a good time to start making plans for you and the baby. You may want to give some thought to the questions in Chapter 8, "Deciding What's Best For You And The Baby". Working out your plans ahead of time can make the adjustments easier after the baby is born.

Your breasts are larger now. They won't grow much more. You may notice some thin yellow liquid coming out of your nipples. This is called COLOSTRUM. This is a sign that the breasts are getting ready to make milk.

Around the fifth month, you can expect to feel the baby move for the first time. This is called QUICKENING. These movements feel like a gentle flutter and will not hurt. Your doctor will want to know the date when you first felt the baby move.

The uterus and the baby have grown so much that they don't fit down in your pelvis any more. The uterus moves up into your abdomen and, for the first time, you look pregnant. Your waist is bigger, and you stick out in front. You shouldn't have to go to the bathroom as often because there is less pressure on your bladder.

There are many customs in the Southwest to protect the unborn baby. Many women wear keys around their waists to protect their babies from harm.



Fifth Month

FOURTH MONTH

The baby is floating in his bag of warm water and can turn and tumble like an acrobat. He kicks, rolls over, turns from side to side, and waves his arms and legs. This swimming is exercise for the growing baby. It helps him develop his muscles and bones.

The baby wakes and sleeps inside his bag of water. When he is sleeping, he will find his most comfortable position. He is probably the most comfortable when his mother is walking around slowly. When she is moving, he is rocked gently back and forth in the water.

The cord is between 18 and 21 inches (46-53 cm) long and is full of blood moving through it. Because it is stiff and slippery, it almost never gets knotted as the baby moves.

SIXTH MONTH

The baby's body is covered by soft hair called LANUGO and a white, creamy coating called VERNIX. These will protect his tender skin during the long months in the water. The lanugo is thickest around the baby's eyebrows, eyelashes, and upper lip. The vernix builds up in these areas, and the fetus looks like an old man with white hair.

THIRD TRIMESTER
The seventh, eighth and ninth months

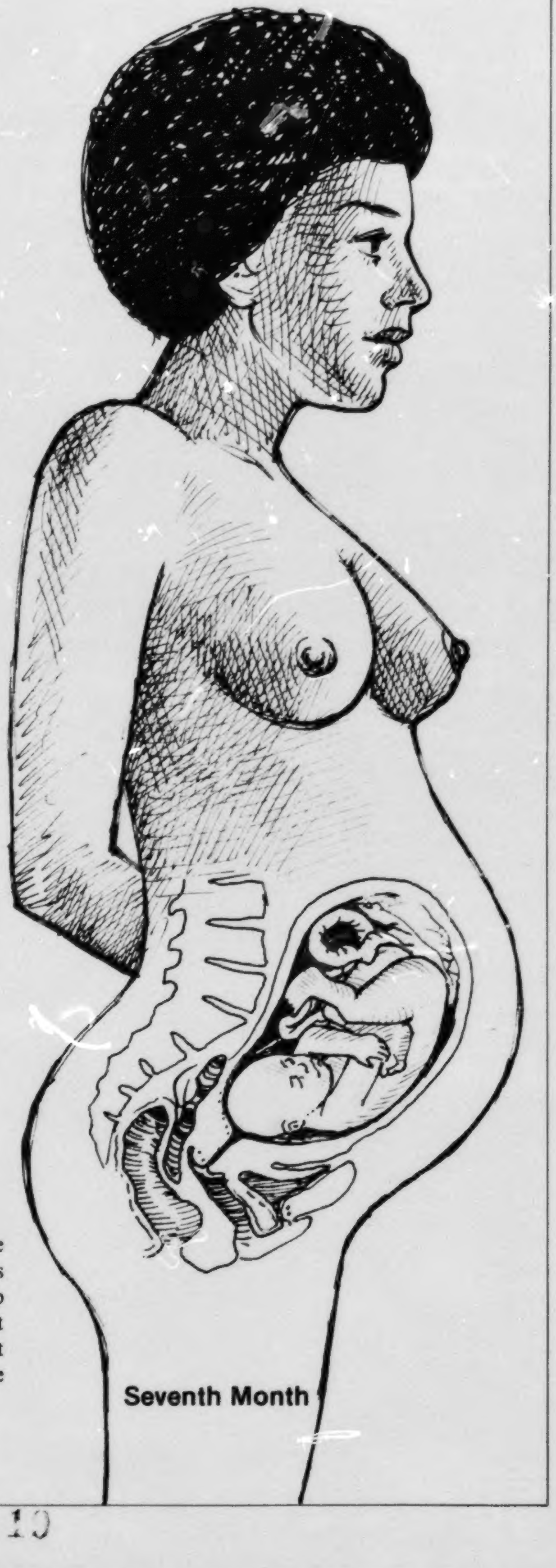
The third trimester is often called the "watchful waiting (weighting)" time. You are waiting for the pregnancy to end and you also gain the most weight. The uterus continues to stretch and grow. It presses against the organs inside your body. You may find it hard to breathe when you climb stairs or move too quickly. You also may notice that you "waddle" when you walk.

During this time, the muscles in your uterus will become stronger. You may feel them tighten once in a while. These painless contractions help strengthen the muscles and prepare them for labor.

Mothers often think and dream about the baby inside them. They may imagine what the baby looks like or what sex it will be. You may wonder if the baby is growing normally or worry that something may go wrong. At times, you may wonder if you will be a good parent. You have already begun to be a good parent if you are taking good care of yourself and the baby inside you. This is the greatest gift you can give yourself and the baby.

You may feel warmer than everyone around you. You may be fanning yourself while others are freezing. If you lie on your back in bed, it may be hard for you to breathe. Sleeping on your side will help. You may notice your heart fluttering from time to time. All of these things are normal.

The baby's movements become stronger and stronger. You may feel like you're being kicked in your ribs and on your bladder at the same time! Just as you start to go to sleep, the baby decides it's playtime. At times like this you may feel tired and angry. On the other hand, it's a good feeling to know the baby is active and strong.



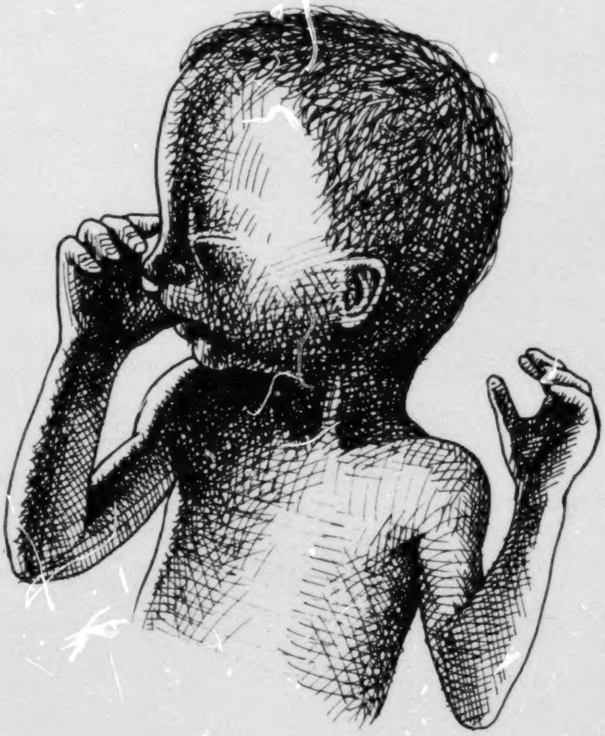
Seventh Month

In the Southwest, many women are taught to keep their feet warm at all times during pregnancy. Some are taught to keep their feet off of the floor. Many girls do not go barefoot. It is believed that cold feet make the womb get cold and this can cause problems in the pregnancy.

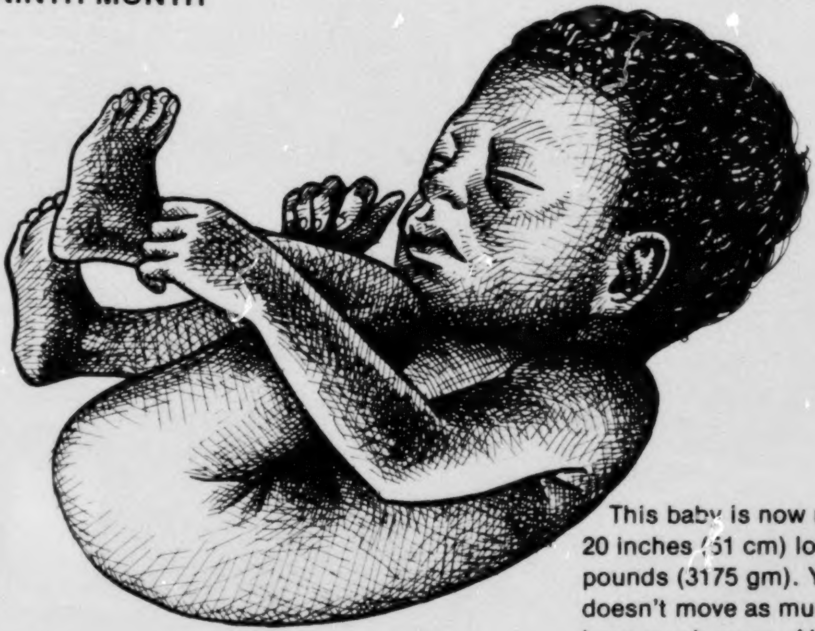
SEVENTH MONTH

The unborn baby is able to do many things in these last months of prenatal life. If he were born now, he would probably live. He can hear quite well. He listens to the sounds inside your body, such as the beat of your heart or the growl in your stomach. He can also hear the sound of loud voices and other loud noises. He can see, too. He doesn't see shapes, but is able to tell light from dark. After the baby is born, he will be able to recognize his mother by the sound of her voice long before he can see her clearly.

The baby is getting bigger and putting more fat on his body. He still moves, but it is getting more crowded inside the uterus. The unborn baby learns a lot about his mouth before he is born. He can suck on his thumb and swallow the water around him. He will practice this when he is awake, and by the time he is born, he will be able to suck and swallow well. This will be his only way of getting food during the early months of life. He cries, too, but you can't hear him because there is no air in his lungs. You may notice his hiccoughs when you feel little jerks in your abdomen.



NINTH MONTH



This baby is now ready to be born. He is about 20 inches (51 cm) long and weighs around seven pounds (3175 gm). You may notice that he doesn't move as much now because he doesn't have much room. All of his organs are formed and are working. He can see, hear, move, cry, suck, swallow, and feel. He is ready to live in the outside world.

READY FOR BIRTH

The last month of pregnancy may seem like a long one. You will be eager for the pregnancy to be over. Yet, you may also be scared for labor to start. Since this is a new experience for you, it is normal to wonder what labor will be like and how you will do.

You may feel very "fat" and be tired from carrying all of this weight around. You may feel so "stuffed" inside that it's hard to get comfortable, and you may have trouble sleeping.

In nine months your uterus has grown from the size of a pear to the size of a gallon milk jug. Your waist may be almost twice as big as it was before. But soon, you will be able to see your feet again and begin to wear your regular clothes!

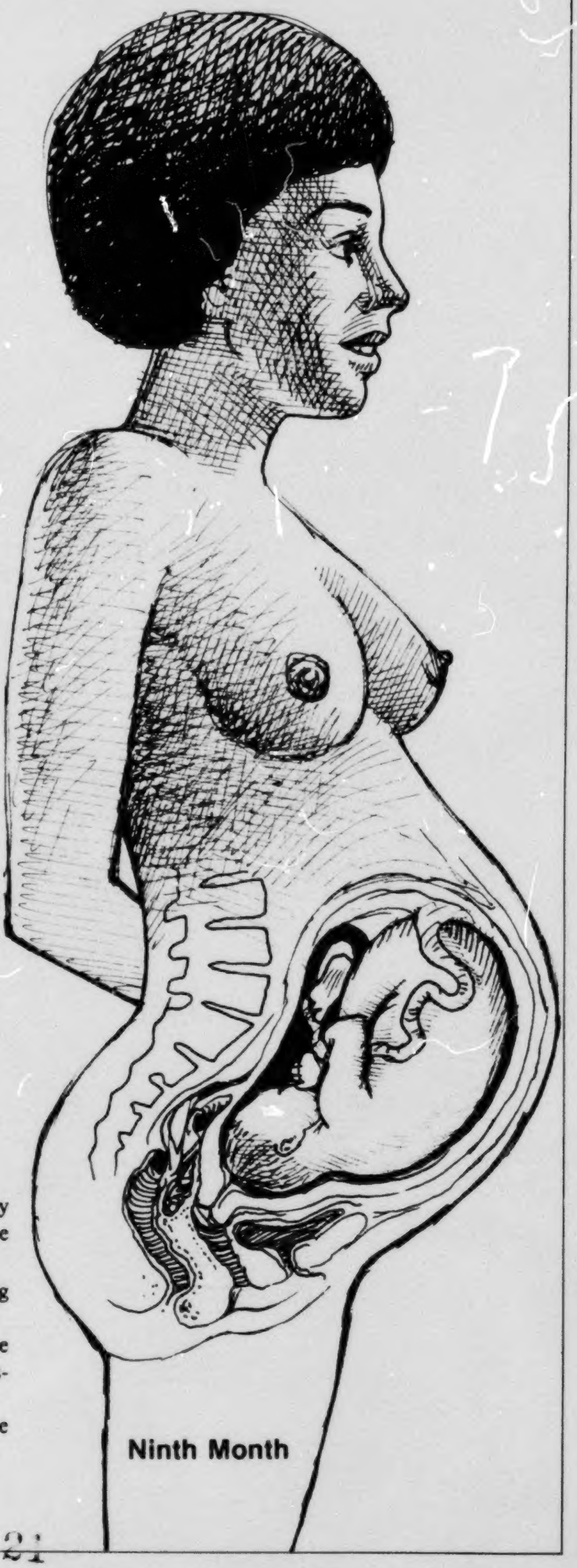
Sometime during the last month of pregnancy, the baby will settle low in your pelvis. This is called ENGAGEMENT, "lightening", or "dropping". This is a sign that your body is getting ready for labor.

You are getting ready for the baby to come. If you are keeping your baby, you will want to have things ready for him. This is a good time to pack your suitcase for your hospital visit and plan who will be taking you. You may want to make a practice run to see how long it takes to get there.

As your due date gets nearer, friends and family will call to see how you're feeling. If you go past your due date, they may ask, "Are you still around?" This may bother you when no one is more eager than you to have this baby. Each day you may wonder, "Is this the day?" Soon, very soon, your day will be here!

There are many beliefs about pregnancy and childbirth that have to do with the moon. Some of these are:

- If you look at the full moon, something will be wrong with your baby.
- If you look at the moon your baby will be born with a birth mark or will be cross-eyed.
- Babies born during the full moon will be strong and the delivery will be easy.



Ninth Month

YOUR HEALTH CARE DURING PREGNANCY

After you have missed one or two periods, you may think you are pregnant. This is the time to go to the doctor. As soon as two weeks after you have missed a period, a urine test can tell you if you are pregnant. For a safe pregnancy and a healthy, normal baby, start going for prenatal care early. There are many types of health care available for the pregnant woman today. You may be seen by a doctor, a midwife, or a specially trained nurse. The person who gives you your care may be a man or a woman. In this chapter, we will refer to this person as "doctor" or "he".

At your first visit, the doctor or nurse will ask you many questions about your health. Try to answer all of these questions honestly. This information will give the doctor a good idea of what care you will need. The doctor may also ask you what drugs you take and how much you smoke and drink. He isn't being "nosey"! He knows these things can harm your baby. He will ask about your weight just before you became pregnant. This helps him figure out just how much weight you should gain.

One of the most important questions the doctor will ask you is, "When did your last menstrual period start?" You can expect to have the baby about forty weeks after your last period began. If you would like to figure out when you may deliver, add seven days to the first day of your last menstrual period, and count back three months. This will be your "due date" or "EDC" (expected date of confinement). You will probably deliver sometime during the two weeks before or after that date.

After the doctor or nurse has finished with your health history, there are several tests that are done. You will be asked to urinate in a cup. Your urine will be checked each visit to make sure there is no sugar or albumin (protein) in it. If these things are there, this may be a sign of a problem.

Blood will be taken from your arm and maybe from your finger. There are five important tests done on this blood:

(1) V.D. TEST - a test to see if you have syphilis
(2) HEMOGLOBIN - a test to see if you have enough red blood cells, or to see if you are anemic (often called "iron-poor blood" or "low blood")
(3) BLOOD TYPE - you will have one of these types: O, A, B, or AB
(4) RH FACTOR - you will be Rh+ or Rh-
(5) RUBELLA TITER - a test to see if you have had German measles or are immune to them

The results of all these tests will help the doctor know the best way to care for you. If you have any questions about these tests, ask your doctor.

You will be weighed each time you visit the doctor. Your weight is watched closely to make sure you are gaining the right amount. Too little gain may mean that you are not eating enough. This could make the baby too little when he is born. Too much weight gain may be harmful to your health, especially if you have been eating too many "junk" foods! A normal weight gain for most pregnant teenagers is between 24 and 30 pounds (11-13.6 kg). That may sound like a lot of weight! This chart shows where those pounds go.

	Pounds	Grams
Placenta	1½	680
Uterus	2	908
Extra Blood	4	1,816
Baby	7½	3,402
Bag of Water	2	908
Breasts	1	454
Extra Water	2½	1,127
Other	3½ +	1,588
	24 +	

During the first 12 weeks, most women gain only two to four pounds. For the rest of the pregnancy, the weight gain is between three-fourths and one pound per week. This weight is usually lost shortly after the baby is born. Anything above the 30 pounds will be harder to lose. Your doctor will be the best judge of what is the right amount for you to gain.

Your blood pressure will be checked at each visit. The doctor knows what is normal for you. He watches it closely to make sure it does not go up. If it does, he may ask you to cut down on the amount of salt you eat. Also, he may want you to rest more.

A complete physical exam will probably be done. No woman likes this part of going to the doctor! You may feel scared, embarrassed, and shy. This is normal. If you understand why he is doing the exam and what you can do to help, it may not be so bad. First of all, your doctor will probably check your ears, eyes, nose, and throat. Then he will listen to your heart and lungs. Next, the doctor will check your breasts. He is looking for lumps that are not supposed to be there. Also, he may be able to tell by looking at your breasts if they "look pregnant". Have you noticed a change in the size and color of your nipples? You may be able to see the veins under the skin or dark pink streaks, called stretch marks. These are normal changes of pregnancy.

Next, the doctor will want to check the female organs inside your body. This is called a vaginal or PELVIC EXAM. Many women feel embarrassed and scared to have this done. Take a few deep breaths and *relax* all of your muscles. The exam will be over quickly.

The doctor checks for several things during this exam. First, he uses a SPECULUM, which is a plastic or metal instrument that looks like a duck's bill. It may be cold as he slips it into your vagina. The speculum opens up the birth canal so that he can see your cervix (mouth of the womb). He looks for signs of pregnancy and infection. While the speculum is in place, he removes some of the cells from the cervix for a PAP SMEAR. This is a test for cancer. It should not hurt. Also, he will test for gonorrhea ("clap").

Next, the doctor removes the speculum. He will use two fingers to feel the size and position of the uterus. From this he can tell if you are pregnant and how far along you are. He also checks the bones of your pelvis to see if your birth canal is big enough for the baby. The pelvic exam is an important part of your care!

The nurse-midwife checks the size and position of the baby.

The doctor listens for the baby's heart beat.

The doctor will tell you what he has learned. Ask him any questions you may have. No question is too silly! He should give you some instructions about your care and tell you when to come back for your next visit. You will probably be seen once a month until the last two months of your pregnancy. Then, he will want to see you more often.

"When the doctor was checking me I was embarrassed. I didn't know what the heck he was doing . . . I kept asking him questions and he was answering me, but the words he was saying — I didn't even know what they were cause they were big words . . . so I didn't bother asking any more."

If there is something you don't understand, it is important to let your doctor know. It may help to make a list of the questions you want him to answer.

On your return visits, you will be weighed, your urine will be tested, and your blood pressure will be checked. The doctor will check the baby's size and listen for the heart beat. The baby's heart beat will be heard around the 20th week of your pregnancy. The doctor may let you listen to it. It is much faster than yours and sounds like the ticking of a watch.

It is very important to keep all your appointments with your doctor. Get into the habit now of having regular check-ups for you and your baby.

KEEPING YOURSELF WELL DURING PREGNANCY

Part I - Taking Care of Yourself

PREGNANCY IS NOT A SICKNESS! Many young women say they feel better during this time than ever before. It is important that you take good care of yourself so that you will have a healthy, normal pregnancy. You will have many questions about how to do this. In this section we will talk about some of the most common questions young women have about their care. Be sure to ask the doctor or nurse whenever you are not sure of what to do.

How much rest and sleep do I need?

You may feel more tired during some months of pregnancy than others. Most pregnant women need eight hours of sleep each night, with at least one short rest period during the day. If you are very active, you may need more rest than the young woman who sits most of the day.

Can I take baths?

You should take a warm bath (or shower) each day to keep your skin clean. It is also a good way to relax. Toward the end of your pregnancy, it will be hard to get in and out of the tub because your balance is not as good as it was. When this happens, most doctors want you to take a shower because you are less likely to slip and fall. It's a good idea to have someone nearby when you take a bath in case you need help.

What should I wear?

During the first few months of pregnancy, you will be able to wear your regular clothes. About the fourth month, they will begin to feel tight around your waist. This is the time most young women begin to wear looser, more comfortable clothes. Pants with elastic waist bands are the most comfortable. If you want to wear your jeans, you can wear them unzipped part of the way and cover the open zipper with your blouse. Dresses and blouses should hang from the shoulders. Shoes with high heels are hard to walk in, and can be dangerous. Choose shoes with low heels that are comfortable and give your feet support.

New maternity clothes can cost a lot of money. You may want to borrow some from friends or buy used ones at the second-hand store. These often look new because they were not used that long. Take time to find the colors and styles you like. *The better you look, the better you'll feel.*

How should I care for my breasts?

Your breasts will continue to grow until about the fifth month of pregnancy. You will need the support of a good bra that fits well. It is best not to go without a bra during this time because the weight of your breasts can cause them to sag later! Choose a bra that has wide shoulder straps that won't stretch. Make certain the cup is large enough to hold all of the breast tissue. If you plan to breastfeed, you should begin to take special care of your breasts around the seventh month. You will be given a copy of a special booklet about breastfeeding.

What about my teeth?

It is not true that a mother loses a tooth for every child! It is important, though, that you get your teeth checked early in pregnancy. *Be sure to tell the dentist that you are pregnant.* He will want to fill any cavities early and take special care if you need any x-rays. To have healthy teeth, brush carefully after meals and before you go to bed.

You may notice that your gums are red and puffy. They may even bleed when you brush your teeth. This can be helped by brushing often with a soft brush and by eating lots of fresh fruits and vegetables.

What kind of work can I do?

If you have a job, you may wonder if you have to quit because you are pregnant. Whether or not you can keep working depends on the kind of work you do, how you feel, and the advice of your doctor. If your job requires strenuous exercise, such as heavy lifting, you may not be able to continue to work. If not, you should be able to work during most of your pregnancy. Your doctor can tell you if you need to stop working.

Housework can be a good form of exercise. It can keep you active while you are at home. It is not a good idea for you to lift anything heavy or move furniture. When you begin to feel tired, take short rest periods.

Housework cannot harm the baby. Some people believe that raising your arms above your head to hang up clothes will wrap the cord around his neck. This can't happen because there is no connection between your arms and the baby inside!

Many household cleaners, bug sprays, and paints can be dangerous. Check the label on the can for special warnings. Use only lead-free paint. Be sure you have plenty of fresh air in the room when you use any of these things. Wash well when you finish.

Is it safe to travel?

If the pregnancy is going well, most doctors think it's safe to travel. You may become tired from sitting during a long car trip. It helps to stop every hour or two so you can get out and move around. It's a good idea to check with your doctor before you plan any trips, especially during the last three months of pregnancy.

Can I make love?

You do not have to stop having intercourse while you're pregnant. As long as your pregnancy is normal and you feel comfortable, there is no medical reason to stop. However, most doctors warn against intercourse if the woman has pain, bleeding, or cramping during or after making love. Tell your doctor if you have any of these signs.

Sometimes a woman's feelings about sex change during pregnancy. Some say they aren't interested in sex, while others say they are even more interested. If your feelings change, it is important to talk it over with your partner. He will need to know where you're coming from. Think how confusing it can be for him if you suddenly change the way you act.

You may also be afraid that he won't think you're attractive while you are pregnant. All men are different, so you'll want to check this out with him. Many young men are afraid that making love will hurt the baby in some way. You can tell him that the baby is protected by a bag of water. It is *not* true that having sex will give your baby a flat head or make your labor last longer.

Loving and touching are important to everyone. There are many different ways of showing you care. Sharing your thoughts and feelings can bring you closer together.

What about exercise and sports?

Regular exercise is a big part of staying healthy. It is good for your body *and* for your mind. While you're pregnant, you can still do many of your regular activities. Go ahead and have fun. Just stop when you begin to feel tired!

If you are used to sports, you will still be able to do most of them. Walking, swimming, and even dancing, can be good for you while you are pregnant, as long as you don't overdo it. It's best to stop rough sports that can cause bumps or falls. Things such as skiing or football are not safe for you.

Are there any kinds of exercises I can do to help me with labor and delivery?

There are two kinds of exercises that will help you get ready for labor. One kind will help get your body in shape (strengthens muscles). The other kind will teach you how to relax and breathe correctly. It is important to begin doing these exercises now. *The more you practice, the easier it will be for you to relax and do the work of labor.* If possible, practice them with the person who will be with you during labor. They can be done every day. You will find that many can be done while you watch T.V. or study! (For more information, see booklet on exercise.)

Can I douche?

Douching is cleaning the *inside* of the vagina with a stream of water. Even when you are not pregnant, douching is not a good idea. When you are pregnant, *don't douche at all unless it is ordered by your doctor.* It could carry germs into your uterus. The best way to keep yourself clean is to bathe every day or wash *outside* the vagina with a washcloth and soap.

Part II - Common Complaints (Things that may bother you)

Pregnancy causes many changes in your body. You may feel certain discomforts you have never had before. *Most of these are not serious*. There are things you can do to help yourself feel better.

Nausea and Vomiting - "Morning Sickness"

You may have noticed a sick feeling when you wake up in the morning, or maybe late in the afternoon or evening. Perhaps you even threw up (vomited). Most of the time nausea and vomiting stop by the third month of pregnancy, when your body is used to all of the changes.

What can you do?

Eating a few crackers before getting up in the morning may help. For breakfast, eat a dry food such as toast or a tortilla. Wait an hour or two before drinking milk or juice. Eating four, five, or six small meals a day or light snacks between meals may help. If certain smells, such as smoke or fried foods, bother you, then get some fresh air. Remember, morning sickness should go away soon.

Dizzy Spells

You may notice that you feel faint or dizzy when you get up quickly or when you have been standing for a long time. Some women even faint! Unless this happens to you often, do not worry about it.

What can you do?

Getting up slowly or putting your head down between your knees will help the blood to flow to your brain so you will feel better.

Frequent Urination

Early in pregnancy you will have to go to the bathroom more often. The growing baby and uterus press on the bladder where the urine is stored. This gives you the feeling that you need to urinate.

What can you do?

If this bothers you a lot at night, don't drink much after 6:00 p.m. Remember, you will need six to eight cups of liquid a day to help you get rid of the wastes for both you and the baby. By the fourth month, your uterus will move up into the abdomen. This takes the pressure off of your bladder, so you won't have to go to the bathroom as often. When the baby drops, during the ninth month, you will again have to go to the bathroom more.

Constipation

You may have noticed that you do not use the bathroom (have a bowel movement) as often as you used to.

What can you do?

Eat plenty of fresh fruit and vegetables, drink lots of water, and eat whole grain breads and cereals (such as bran). This should help you use the bathroom more easily. Eating prunes may also help. Other things you might try are regular exercise and using the bathroom at the same time each day. Pick a time when you can be in the bathroom without being bothered. If you still have trouble with constipation, ask your doctor for help. NEVER take laxatives, medicines, or enemas without talking to your doctor.

Heartburn

"Heartburn", which has nothing to do with the heart, is really a kind of indigestion. It causes a burning feeling in the chest and throat. This happens because the uterus pushes up against the stomach as it grows. Food does not digest as well, so you may burp or have a sour taste in your mouth.

What can you do?

Eat smaller amounts more often. Don't lie down after you eat. Stay away from rich, fried foods and desserts. Drinking some milk may help. If you need to take medicine for heartburn, ask your doctor and he will tell you what to take. *Alka Seltzer or baking soda in water may be dangerous to you and the baby.*

Muscle Cramps

Did you ever wake up at night with a cramp in your leg? During the last months of pregnancy, leg cramps are common because the pressure of the large uterus slows down the flow of blood in your legs.

What can you do?

If you are in bed, bend your foot forward with your hand. Sometimes rubbing the leg will help. A heating pad or warm water bottle can feel good, too. Sometimes leg cramps are caused by not getting enough calcium in your food. Drinking more milk may help. Placing a rolled-up blanket under the covers to rest your feet against at night will help, too.

Have you ever had a pain in your side? This is called a "stitch" and is caused by a cramp in the ligaments that keep your uterus in place. Although it may be uncomfortable, it is not harmful to you or the baby. Sitting or lying on your side should help.

Backache

Many young women have backaches sometime during pregnancy. The uterus is growing and is sticking out in front. This puts a strain on your back.

What can you do?

Standing up straight and doing the prenatal exercises can help a lot. If you have been wearing shoes with high heels, change to lower ones. Resting on your left side on a firm mattress or on the floor can also help. Lying on the floor on your back with your feet propped up will rest your lower back.

Vaginal Discharge

It is normal to have a heavy discharge (white stuff) in your panties while you're pregnant.

What can you do?

Daily baths will help you feel clean. If the discharge makes you itch or burn, or if it has a bad smell, tell the doctor. You may have a common infection which he can treat.

Stretch Marks

Have you noticed dark pink lines on your breasts or abdomen? These are called "stretch marks" and are caused by hormone changes and the stretching of your skin.

What can you do?

There are no magic oils or creams to prevent them. They will turn a lighter color after the baby is born. If your skin is dry and itchy, using hand or body cream may help. Try not to scratch because this can make stretch marks worse!

Stuffy Nose

Some women have a stopped-up nose during most of their pregnancy. This swelling in the lining of your nose is caused by the extra water in the body. At times your nose may bleed.

What can you do?

Adding steam to the air with a vaporizer may help. You can keep the inside of your nose from cracking by using a little Vaseline, Mentholatum or Vicks.

Hemorrhoids

Hemorrhoids are sometimes called "piles". They are swollen veins around the rectum (where you have a bowel movement). The blood vessels swell and can stick out, itch, or hurt.

What can you do?

Preventing constipation or hard stools will help. Try not to push too hard when you use the bathroom. Sitting in a tub of warm water will make them feel better. Lying on your left side with a pillow under your hips may also help. Tell your doctor and he may give you some medicine to use. Hemorrhoids often go away after you have had the baby. *Remember, it is better to prevent varicose veins and hemorrhoids than to cure them!*

Varicose Veins

Varicose veins are blood vessels that have stretched. They are often seen in the legs. The large uterus presses on the blood vessels and slows the flow of blood in the legs. These stretched vessels can stick out and ache.

What can you do?

You can help the flow of blood in your legs by not wearing tight clothes, knee-high stockings, or garters. The blood moves better if you move around a lot and don't sit with your legs crossed. You can lie down with your feet and legs higher than your head.

Shortness of Breath

As you get farther along in your pregnancy, you may find that it is harder to breathe. The uterus pushes up against your lungs and you don't get as much air when you breathe. You may notice that it is easier to breathe the last two weeks of pregnancy. This happens when the baby drops back down into the pelvis.

What can you do?

Walk up steps slowly. Sleeping on your left side or propped up with extra pillows will make your breathing easier. This helps the baby to get more oxygen, too!

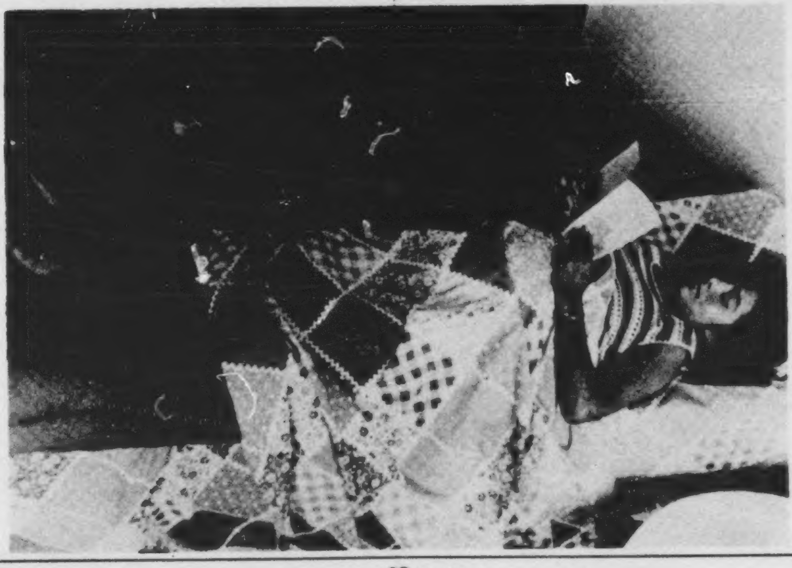
Mask of Pregnancy

Some women get dark areas of skin on their faces during pregnancy. Often they show up around the eyes where a mask would be worn. They are caused by the high hormone levels during pregnancy.

What can you do?

These dark areas get lighter after pregnancy and may go away. Too much sunshine on the face makes them darker. Protect your face from the sun when you are outside. You can use light make-up to cover the patches until they go away.

By now you may be wondering if all these things will happen to you. Of course not! Chances are you may be bothered by only one or two of them. Remember, they are not serious and most will go away after the baby is born. If you have other worries, talk to your doctor and he will do what is best for you and the baby. Taking good care of yourself during pregnancy is the first step in becoming a good parent.



REPORT THESE SIGNS TO YOUR DOCTOR!

- Swelling in your face, hands or feet
- Blurring of vision or spots before your eyes
- Any bleeding from the vagina
- Severe or constant headaches
- Severe, continuous vomiting
- Fever and chills
- Burning and pain when you urinate
- Sharp or constant pain in your abdomen
- Sudden gush or steady trickle of water from vagina

MISCARRIAGE

Bleeding from the vagina during pregnancy is a danger sign that should always be reported to the doctor. It may not be anything to worry about, but only he can tell for sure. Bleeding can be a sign of miscarriage (losing the baby before it can live). Most miscarriages happen in the first 12 weeks of pregnancy. Many times the cause is unknown. Sometimes it is nature's way of preventing the birth of a baby that could not live. If the mother is not healthy, she may miscarry.

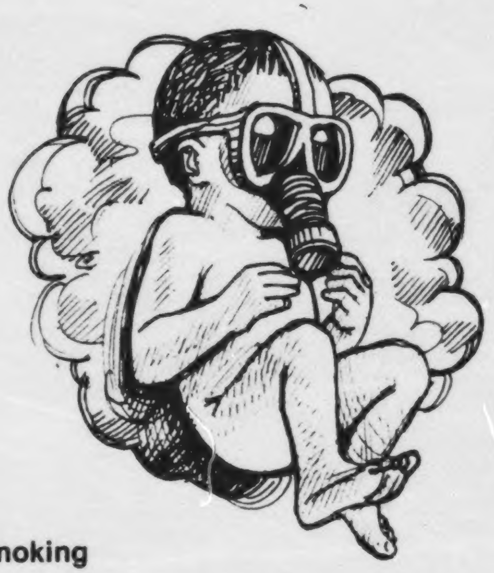
The doctor may tell a woman to go to bed and rest if she is bleeding. If the pain and bleeding get worse, he may put her into the hospital. If tissue is passed, he will probably clean out the uterus to prevent too much bleeding and infection.

Most women are scared and upset when they miscarry. They worry that they can never have a healthy baby. If you do have a miscarriage, this does not mean that it will happen again. If you take good care of yourself, chances are the next pregnancy will be a healthy one.

BE GOOD TO THE BABY BEFORE HE'S BORN

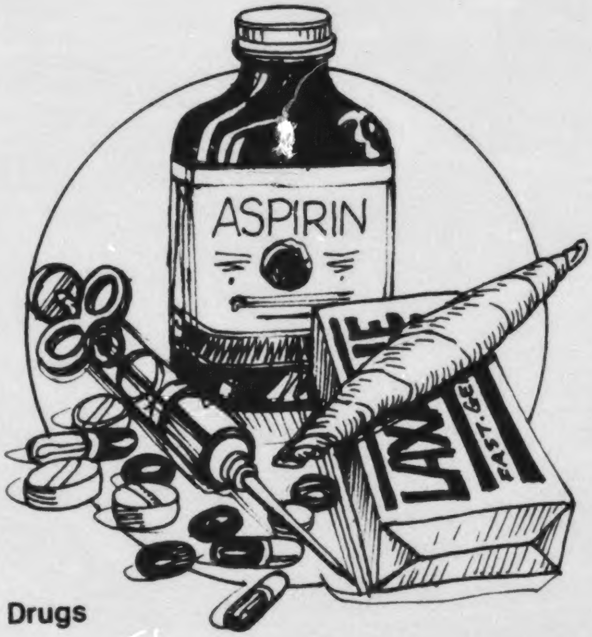
6

Whether you plan to keep this baby or release it for adoption, you will want to give it the best possible start in life. The baby's health depends on what you do while you are pregnant. Here are some things that can be dangerous.



Smoking

Smoking is dangerous to both you and the baby. Mothers who smoke have smaller babies than mothers who do not smoke. The baby's health and life can be damaged if he is too small. Heavy smoking may cut down the number of brain cells the baby has, so he may not be as smart. You are in danger of getting cancer or heart disease. If you do smoke, cut down on the number of cigarettes. Try to "kick the habit" now!



Drugs

Don't take any pills, drugs, or other medicines unless your doctor tells you to. These cross the placenta and get to the baby. Some drugs damage the baby's growth and can cause serious birth defects. Don't take the chance of hurting the baby's body or his mind!

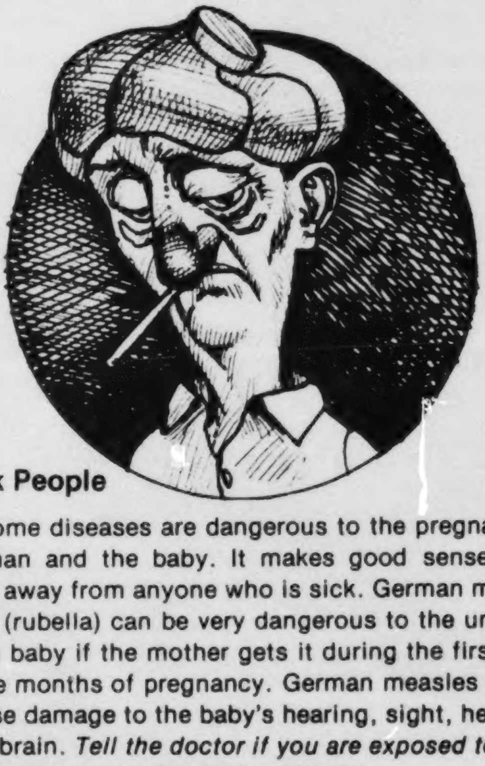
X-Rays

Early in pregnancy, x-rays to the lower abdomen can cause birth defects. Any time you think you might be pregnant, be sure to tell your doctor or dentist. Your doctor may make x-rays late in pregnancy, but these will not hurt the baby.

OLD TIMER
BOUR
BEER

Alcohol

Even small amounts of drinking may be very dangerous to the unborn child. It can damage his looks, his growth, and his brain. Did you know that alcohol can destroy your own brain cells, too? Why chance it?



Sick People

Some diseases are dangerous to the pregnant woman and the baby. It makes good sense to stay away from anyone who is sick. German measles (rubella) can be very dangerous to the unborn baby if the mother gets it during the first three months of pregnancy. German measles can cause damage to the baby's hearing, sight, heart and brain. *Tell the doctor if you are exposed to measles or any other serious illness.*

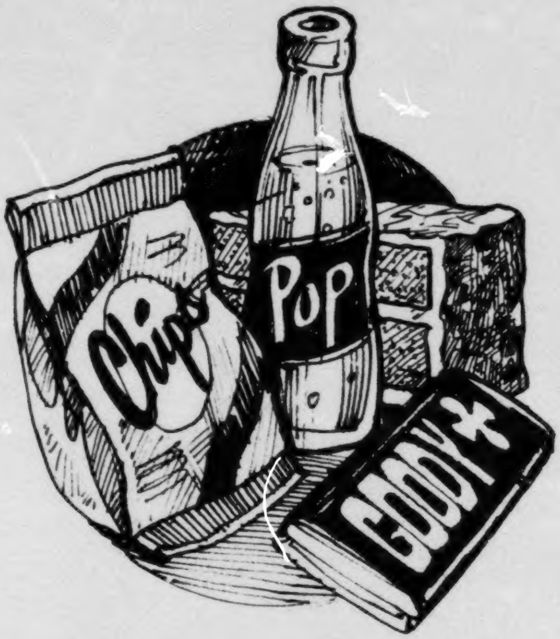
V.D. (syphilis, gonorrhea)

The only way venereal disease (V.D.) is spread is through sexual contact with a person who has it. It is *not* spread by dirty toilet seats or door knobs. The doctor checked you for signs of V.D. at your first visit, but you can get it at any time during your pregnancy. Even if you have had it once, you *can* get it again. If you think you may have V.D., BE SURE TO TELL YOUR DOCTOR. Early treatment can prevent damage to you and the unborn baby.

The two most common kinds of V.D. are syphilis and gonorrhea. The signs of gonorrhea in a man are pain and burning when he urinates (goes to the bathroom) and a "drip" (discharge) from the end of the penis. Women may not have any signs at all. Some women notice a discharge from the vagina that itches and burns. The signs may start 3 to 9 days after sexual contact. If a woman has gonorrhea at the time of delivery, it gets into the baby's eyes as he passes through the birth canal. This can cause blindness.

Syphilis is the most serious of the venereal diseases. A painless sore (chancre) develops on the sex organs or where the germ entered the body. This sore appears 10-30 days after contact with the person who has syphilis. A woman may not know she has this painless sore if it is in her birth canal. There won't be a discharge. The sore will go away in several weeks even if it is not treated, but the person still has the syphilis. Later on, the person may feel sick and uncomfortable. The real harm it does to the body shows up months, or even years, later. It can cause damage to the heart, blood vessels, and brain. If a pregnant woman has untreated syphilis, it can cross the placenta to the unborn baby. The baby will be born with syphilis. At first the baby may look normal, but there can be damage to the heart and bones. This damage may show up years later when the child becomes a teenager.

The important thing to remember is that V.D. can be cured. The baby can be born normal and healthy if you get treated early. DON'T TAKE CHANCES. GO TO YOUR DOCTOR OR CLINIC IF YOU THINK YOU MAY HAVE V.D.!



Poor Diet

The growing baby depends upon you for food. A poor diet can damage both of you physically and mentally. Eat well and avoid junk food so you will both be healthy!

Young women often want to know *exactly* what will happen to the baby if they don't take good care of themselves during pregnancy. This is a question no one can answer. The health of the baby depends on many things. We do know that while the baby is inside the mother's body, he depends on her for a safe, healthy place to grow. The baby's body is many times smaller than the mother's and is more easily damaged. If she doesn't take good care of her own body, the chances are that this will affect the baby.

The causes of most birth defects are still not known. More and more research is being done to find the causes. We already know that the things in this chapter are dangerous.

If you take good care of your body during pregnancy and avoid these dangers, you will be doing everything you can to have a healthy baby.

DON'T BELIEVE EVERYTHING YOU HEAR!

It's not true that:

If you have a lot of heartburn, your baby will have lots of hair

Lemons, grapefruit, or oranges will thin your blood

If you sleep too much, the baby will stick to your back

Death passes over your head nine times while you're in labor

Your stomach will blow up if you go out on a windy day

Riding on a bumpy road will cause you to lose the baby

If you sleep too much, your labor will be harder

Falling down will cause you to lose the baby

EATING FOR TWO

7

Most of us like to eat. Eating can give us a lot of pleasure. Sometimes we eat because we're hungry or maybe because we're nervous or bored. Often we eat because we are spending time together with family and friends. We eat at weddings, parties, holidays and funerals.

As children we learn to eat the foods that our families eat. Our food habits are also affected by the part of the country we are from. If you live near the ocean, you have probably learned to like fresh fish. If you have grown up in the Southwest, you probably like chile and beans. What we like and how we feel about eating is different for each of us. When you learn how important good food is to you and the baby, your feelings and what you eat may change.

> *"I'd rather eat just anything, but I know eating well is so important for me and my baby. But, it's hard to force myself to eat three good nutritious meals a day when I'd rather drink Cokes and eat cookies."*

> *"Eating well during pregnancy is really neat, cuz you don't put on weight that shouldn't be there. It helps my complexion not to break out. Also we save money cuz there isn't any expense on candy or Cokes when we're driving around. I guess either way you look at it, it's a good benefit!"*

Food is needed for growth

There are two times in a person's life when growth is especially fast — as a baby and as a teen! The baby grows very fast before he is born and during the first year of life. Before birth, the baby is building his whole body. He is forming his bones, organs, muscles, and brain. *Everything about him is built from the food his mother eats while she is pregnant.* The kind of body and mind your child will have depends on what you eat.

During the teenage years, the body begins to grow fast again. Teenagers need to eat more body-building foods than they needed while they were small children. So, when a teenager becomes pregnant, she is eating for her own growth *and* for her baby's! For this reason, it is especially important for the pregnant teenager to eat well. If she doesn't, she is taking a big risk for herself as well as her baby.

People enjoy giving a pregnant woman advice about what she should eat. Some of that advice may be good, but some of it won't be. It is often confusing to tell which is which. It is best to follow the advice of your doctor or nutritionist to be sure.

You will probably be told to eat a "well-balanced diet". You may not know exactly what this means. The best way to make sure you are getting the right foods is to eat a variety of foods each day. We have included a chart showing the kinds of foods needed by you and your baby and why they are important. If you follow it carefully, you will have a "well-balanced diet". Whether or not you do this is up to you.

> *I feel really good about having to eat well while I'm pregnant. It makes me feel like I'm doing something good for my baby!*

Eating right helps mothers

Mothers who eat well
. . . are healthier during pregnancy
. . . are stronger for labor and delivery
. . . have a normal weight gain
. . . have a better chance of being able to nurse their babies
. . . handle their emotions better
. . . get their figures back easier

Eating right helps babies

When the mother eats well during pregnancy, her baby has a better chance of

. . . being born healthy
. . . having a well-formed body
. . . weighing a normal amount
. . . developing plenty of brain cells

> *Sometimes it is hard for me to stick to a good diet while pregnant. I don't want to gain a whole lot except for the baby weight. That way, the baby will be healthy and I'll get my figure back. I can't eat a lot of junk food, which I like to do.*

What is "eating for two"?

This means that you are eating to nourish your own body, as well as the body of your growing baby. The only food the baby ever gets is what you eat every day.

Does this mean I get to eat twice as much?

Sorry, it doesn't. Remember, this second person is still quite small, so you don't need to double the amount of food you eat. You do need to eat very well though, to make sure the baby gets everything he needs to develop normally.

Is it true that all pregnant women have strange food cravings?

No. Some women do have cravings for certain foods at strange times. You've probably heard of pregnant women wanting pickles and ice cream at midnight. As long as the craving is for foods that are good for you, go ahead and eat them.

If you crave such things as starch, dirt, or clay, it is *not* a good idea to eat them. They are *not* good for you! This may mean that you are not getting enough iron in your diet. Be sure to tell the doctor if you crave these things.

It is not true that eating lemons will thin your blood. In fact, lemon juice is a good source of Vitamin C.

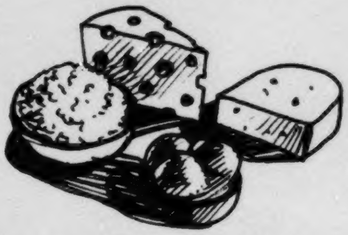
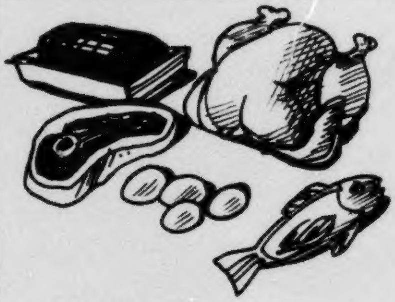
Are there any foods that can hurt the unborn baby?

There are lots of stories about this. You may have heard that strawberries can mark the baby. Or that green chile will give him a rash. How about this one? Eating onions will give your baby bad breath. These stories aren't true! *All of the foods that are good for you are also good for the baby!* Let this be your guide.

Is it true that I can't eat salt while I'm pregnant?

Some women have trouble with swelling in the face and hands. If this happens to you, your doctor *may* ask you to cut down on the amount of salt you eat.

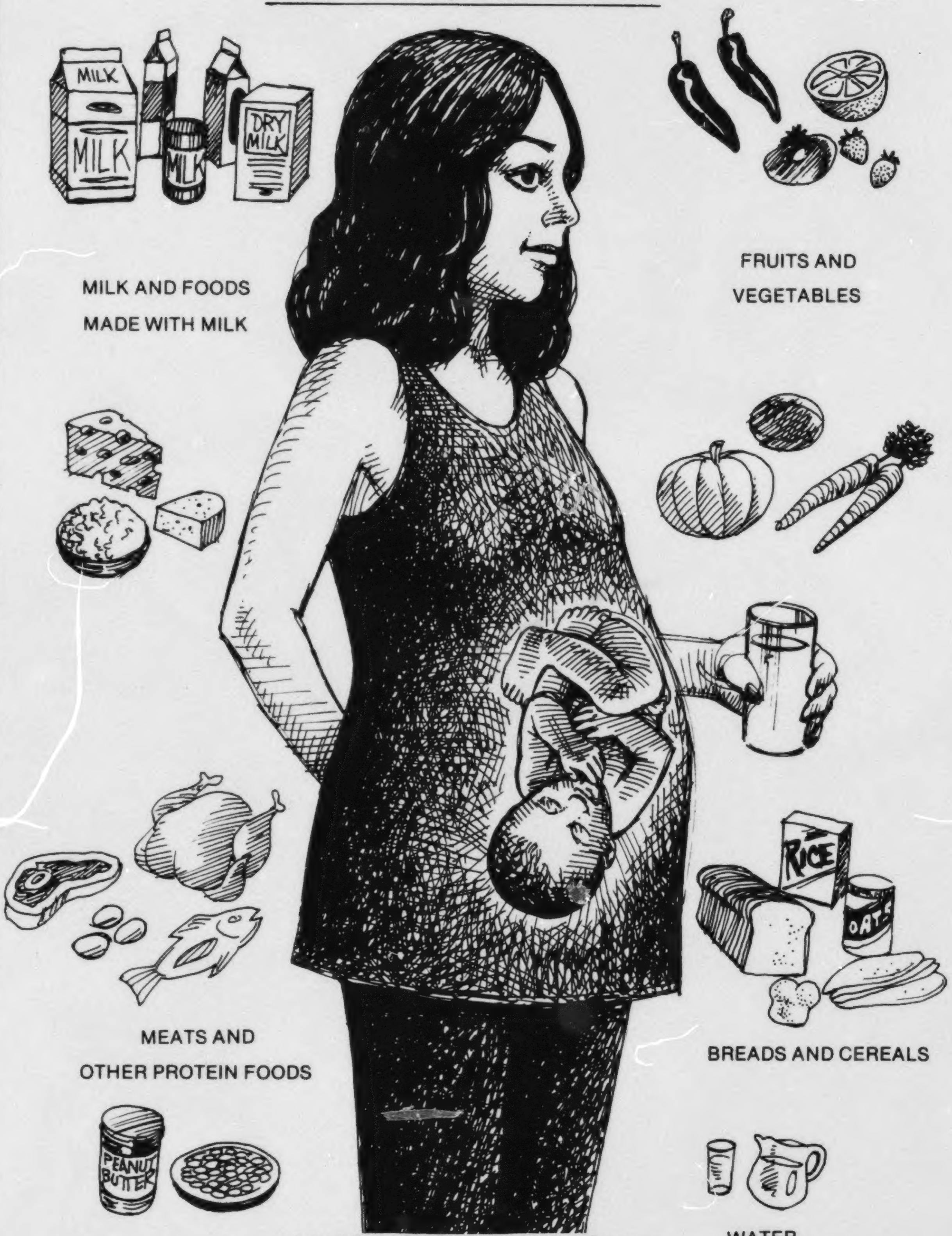
EATING WELL DURING PREGNANCY

You and your baby need:	How much you need each day:	What it gives you and the baby:
 Milk: whole, skim, powdered, canned, buttermilk  *also:* cottage cheese, yellow cheese, ice cream, yogurt and other foods made with milk	**4-5 servings** one serving is: 1 (8 oz.) glass milk ½ c. cottage cheese ½ c. ice cream 1 c. yogurt 1½ slices cheese	Calcium: Needed to build strong bones and teeth; helps nerves and muscles work well Protein: The building block of the body, brain, and blood; needed to build a strong body and mind and keep them healthy; important for recovery after delivery Vitamin D: Helps the body use calcium; prevents rickets Vitamin A: "Good Looks Vitamin"; needed for eyes, skin, hair, and normal body growth
 **Meat and other protein foods:** meat, fish, chicken, eggs, chitlins, menudo, liver *also:* pinto beans, dried peas, nuts, soybeans, peanut butter	**3 or more servings** one serving is: 2-3 oz. meat (the size of the back of your hand) 1 egg ¾ c. cooked beans ¼ c. peanut butter ½ c. nuts	Protein: The building block of the body, brain, and blood; needed to build a strong body and mind and keep them healthy; important for recovery after delivery Folic acid: B Vitamin needed to help the body use iron Iron: Needed for red blood cells, which carry oxygen through the body; prevents anemia ("low blood"); baby's body stores iron during pregnancy for use after birth B Vitamins: Needed for healthy nerves, good appetite; helps body use other nutrients

 Fruits and Vegetables: *for Vitamin C:* oranges, lemons, grapefruit, strawberries, green chili, tomatoes, brussel sprouts, broccoli *for Vitamin A:* green or red chili, carrots, spinach, greens, cantaloupe, pumpkin, any dark yellow or dark green fruits and vegetables	**4-5 servings** one serving is: ½ c. cooked or canned 1 c. raw 1 piece fruit *Choose at least one serving of Vitamin C each day. *Choose at least one serving of Vitamin A each day.	Vitamin C: Helps keep body healthy; needed for teeth, gums, bones, body cells, and blood vessels Vitamin A: "Good Looks Vitamin"; needed for eyes, skin, hair, and normal body growth
   Breads and Cereals: whole grain or "enriched" bread, cereal, muffins, tortillas, fry bread, buns, rice, macaroni, noodles. (Stay away from cereals that have a lot of sugar or food coloring in them.)	**5-6 servings** one serving is: ¾ c. dry cereal ½ c. cooked cereal 1 slice bread 1 large tortilla ½ c. cooked noodles, rice or macaroni 1 bun or biscuit	B Vitamins: Needed for healthy nerves, good appetite; helps body use other nutrients Iron: Needed for red blood cells, which carry oxygen through the body; prevents anemia ("low blood"); baby's body stores iron during pregnancy for use after birth
Water: alone or in other fluids	**6-8 (8 oz.) glasses**	Body Fluids: Help the body use the food you eat and carry wastes out of the body

Keep a record of what you eat each day. Count the number of servings you had in each group. Are you getting all you need?

You And The Baby Are What You Eat!


MILK
MILK
MILK
DRY MILK
MILK AND FOODS MADE WITH MILK
FRUITS AND VEGETABLES
RICE
OATS
MEATS AND OTHER PROTEIN FOODS
BREADS AND CEREALS
PEANUT BUTTER
WATER

All of these foods are important for your health and the baby's growth.

Choose foods from each of the four food groups and drink lots of water every day.

Special Food Tips for Pregnancy (or any other time)

Be sure to

. . . eat from each of the food groups listed on the chart every day.

. . . choose foods you like from each group.

. . . stay away from candy, chips and soft drinks. These are called "junk foods". They are fattening and do not provide vitamins or minerals you need.

. . . choose real fruit juices and not fruit drinks. The label on the can will tell you if it is real juice.

. . . keep eating the foods listed on the chart if you breastfeed your baby.

. . . ask your doctor or nutritionist for information about food stamps and special food programs if you are having problems buying enough food.

. . . find out what is in the foods you buy by reading labels on the boxes or cans.

. . . save money by buying the brands of food that cost less.

. . . stay away from cereals that have a lot of sugar or food coloring in them.

MAKING DECISIONS FOR YOU AND YOUR BABY

8

Once you find out that you are pregnant, there are some decisions you will want to make about you and the baby. Maybe your parents have made most of your decisions for you up to this time. Now, you have to make your own decisions. You have to think of two people — you and your baby — when you make these decisions.

You may wonder if you should keep the baby or release it for adoption. Will you marry the baby's father now? Should you stay in school? Whose needs should you think of first . . . your own? . . . the baby's? . . . your family's? . . . the baby's father? You may feel very confused and upset. _Before_ you make your decisions, take time to sort out your thoughts.

It's best if you can make the final decisions yourself. But before you do that, it's helpful to talk things over with someone you trust. Discuss your thoughts and feelings with someone who will listen to you and not "put you down" or tell you what to do. This may be a counselor or social worker, your parents, the baby's father, a teacher, or a friend.

Here are some things you may want to think about before you decide:

. . . What are your own needs and future plans?
. . . What are the needs of your baby?
. . . What are the feelings of the important people in your life?

Exploring Your Choices

What choices do you have?

You will want to think about how many choices you really have. Before you became pregnant, you may have had dreams about your future. Now, you may feel you don't have much choice about the way things will be. You may have more choices than you think!

You may need help in thinking about what would happen as a result of your making one choice or another. Talk this out with someone. Which choice seems to lead to what you want for you and your baby? Which decision would you be happiest with?

Each person's situation is different. Some of you may not have as many choices as others do. You can make the best of whatever situation you are in, so that you and your baby can make the most of your lives. You can do some thinking about the choices you *do* have. Don't worry about the things you can't change.

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KEEPING OR RELEASING THE BABY

The first step in clearing your head is to begin to ask yourself these questions *honestly*. The answers will give you important clues about what to do.

Do I understand what is involved in being a parent?

. . . Do I know what a child needs and wants?
. . . Can I give up things I want so my child can have more?
. . . Do I like children as well as babies?
. . . Do I like making decisions for two instead of just myself?

What do I want for my life?

. . . Do I really want to be a mother now?
. . . Am I ready to take care of a baby full time every day?
. . . Do I feel ready to become a parent for at least 18 years?
. . . Will I be unhappy when I stay home with my baby instead of going out with friends?
. . . Am I ready to give up some of my freedom now?
. . . Will I be able to finish school?
. . . What are my plans for the future?
. . . Can I get what I want to out of life while I am raising my child?

What plans could I make for a baby?

. . . Where would I get money for food, clothing, and rent, along with the things I need?
. . . Where would we live?
. . . Who would take care of the baby while I go to school or work?

How will I feel if I release the baby?

. . . If my parents want me to keep it, will I feel O.K. about releasing?
. . . Do I understand that this decision can never be changed?
. . . Will I feel good about the baby's new parents?
. . . Can I handle the loneliness I may feel?
. . . Will the baby's father be willing to sign the release?
. . . Am I releasing my baby through an agency I trust?

What about the important people in my life?

. . . How will the baby's father fit into this decision?
. . . How will my family feel if I keep the baby (or place it for adoption)?
. . . How will I fit in with my friends?
. . . Can I count on help from my parents?

Some cultures have beliefs about keeping and releasing babies. Is your cultural belief important to you?

Keep asking yourself these questions until you have honest answers for them. How do you feel about these answers? *Your feelings are just as important as your thoughts*. Keep working on your decision until your thoughts and your feelings are pretty much alike. Remember, it's best not to hurry this decision. Take as much time as you need to decide.

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If I've never been a parent before, how do I know if I'll like it?

This is a simple question that is hard to answer! One way to test this out is to picture yourself as a parent.

Find a spot where you can be alone. Relax and close your eyes. Now picture yourself as a parent:

. . . bathing the baby
. . . holding a crying baby at 3 a.m.
. . . playing with the baby
. . . staying home with the child
. . . feeding the baby
. . . doing laundry

Some of these things are much more fun than others!

How do you feel when you picture these things? Do you enjoy these thoughts of being a parent? Do you feel uptight or tense?

These feelings are good clues about whether or not you will like being a parent.

Can I be a mother and still be me?

This is a question many teenage girls ask. Your life will never be quite the same after you've had a baby. If you decide to keep the baby, your life will be a whole lot different. Babies need lots of love and care. They depend on you for all of these needs — 24 hours a day. You will not be as free to come and go as you were before. Of course, how much freedom you have will depend on whether or not you have someone to help you take care of your child.

On the other hand, being a parent may make you a better person. You will grow up because of having to think about someone else. Giving and caring are things that help many people to mature (grow up).

My mother will take care of my baby for me.

Many teenagers believe that their parents will be happy to raise their child for them. If you are thinking like this, *talk it over with your parents BEFORE the baby comes.* Be sure that all of you agree on who will take care of the child. Most parents are willing to help, but they do not want to take on full responsibility for the baby. You probably don't want them to take over that much. Those that do may begin to feel that the baby is theirs. This can be a big problem for all of you. If you plan to live with your parents after the baby is born, you will want to work some of these things out ahead of time.

Is it possible to raise a child without a father?

Many unmarried girls worry that a child will have problems if he grows up with only one parent. It is true that there are many advantages to being raised by two loving parents. It is harder for a single parent to meet all of a child's needs. It is hard work to do it alone, but *it can be done*. Many women have done it. If you plan to raise your child alone, try to arrange to get help from your family or friends. Your child (whether a boy or a girl) needs to have contact with a male who has an interest in him. Your child can learn about men by spending time with grandfathers or uncles in the family.

How will the men in my life feel about my having a child?

You are young, and you have a good chance of finding the right man for you, if you haven't already. Sometimes, it can be hard to lead a single life and be a mother at the same time. If you are a single parent, it's best to be honest about having a child. A man who likes children may be attracted to a woman with a child. Others may be jealous of the time and attention you give to your little one. It's best to talk over these things honestly when the relationship starts to get serious. Work all this out before you decide to get married. It will be important that your new husband or boyfriend has a good relationship with the child.

How can I expect to feel if I release the baby for adoption?

Almost no one *wants* to release a baby for adoption. When mothers release, it is because they have decided it is best for the baby they love, and for themselves.

Of course, no two people feel exactly the same about this. Many girls say they feel relief and are sure about their decision to release. Others may not feel as sure.

At some time, you can expect to feel upset over the loss of your baby. This may come shortly after it is born, or much later. Once in a while, you may have doubts about whether or not you made the right decision. (Young women who keep their babies also have these doubts!) At times, you may wonder how the child is doing. This often happens on birthdays and special occasions. As time goes by, you will feel more comfortable and will accept your decision as being the best one you could make at that time.

“I've decided to keep my baby. Some people thought it was a good choice, and some thought it would ruin my life. Of course my life will be different, but I know that I'm going to have something special that will make it all worthwhile. And I know I'll really love my baby.”

“The most important decision I had to make about my pregnancy was deciding whether to keep the baby or give it up for adoption. People reacted differently because I decided to release the baby. Some people realized that I was making the right decision for me and the baby, while others couldn't understand how I could do a thing like that. But I know I'm making the right decision, and that's all that really counts.”

“Keeping my baby has changed my life in many ways. First, I have had to grow up awful quick. Second, I have had to make a lot of sacrifices, like in my social life and with money [not buying junk and things like that]. It is different from what I expected only because it's easier. I thought it would be harder to stay home and give up going out.”

“I'm one of the few at our school who is going to give up my baby for adoption, and it does get tough sometimes. Many of the other girls think I'm wrong, and some really let me know. However, it is my decision, and I feel it's the best one for the baby and me.”

“I knew I would go through with the pregnancy and I knew I would keep the baby. It was just a matter of how I would do it. I guess the hardest thing is trying to decide whether to raise the baby alone, or to let my boyfriend in on it. I know I'll love my baby. I just don't know if I want his father to love him (or her) too. I guess I just don't feel he has any right to the baby.”

The authors of this book have known and loved many teenage mothers who have made each of these decisions. We have seen many mothers raise happy, healthy children by themselves. We have seen them graduate from high school and go on to have jobs or to get more education. We have also seen loving young mothers who were happy with their decision to release their babies for adoption. They, too, were happy and busy. Either decision can be the right one. ***The important thing is that you make the right one for you!***

Early in pregnancy you may not feel ready to think about this decision. You may have too many other things to deal with first. The baby may not seem real to you yet. If you feel like this, you may want to wait for a little time to pass. Then you may feel more like thinking about these things.

MARRYING OR STAYING SINGLE

Your thoughts about the baby's father may have changed a lot since you became pregnant. Maybe he's left you alone. Or maybe he's still in your life, and you're trying to decide about marriage. Your ideas about these questions can help you decide.

. . . How do I really feel about him now?
. . . Is pregnancy the only reason for this marriage?
. . . Would he be a good father for this baby?
. . . Do I want to spend my whole life with him?
. . . Am I ready to leave home?
. . . How does he feel about my plans to go to school, or to have a job?
. . . Do we get along well together?
. . . Do I like his friends? Does he like mine?
. . . Do I agree with his ideas about what a wife should be?
. . . Can we talk things over and work things out when we fight?
. . . Has he ever tried to hit me or the baby? How do I feel about that?
. . . Would we have enough money to live on?

Close your eyes and picture yourself as a wife, at home with this man. Is this a good picture? Is it really *you*?

"The most important decision I had to make was whether to get married or not. I knew I loved him (still do), but when the time comes, you start to really wonder if it is the best thing . . . and if your marriage will work out. I was really worried for a while. I don't regret marrying Marty. I do love him very much. Having a husband is very different from just a boyfriend."

"I felt it was best not to get married until I finish high school. My boyfriend's parents tried to force me to get married. They said that if we didn't get married before the baby was born, it would be a bastard."

Abortion

Abortion is a choice that some women consider. Abortion means ending the pregnancy before the baby could live in the outside world. It is a decision that is usually made in the early weeks of pregnancy.

Whether or not you choose to have an abortion depends upon many things: your own beliefs about life, your religion, and perhaps the feelings of others who are important to you. If you consider having an abortion, it is helpful to talk this over with someone else until you are sure you have made a choice that you can live with peacefully. There are counselors, doctors, nurses, and clergy who are trained to help a woman understand what is involved. If you decide to have an abortion, it should be done by a doctor in a hospital or clinic.

STEPS THAT CAN HELP YOU MAKE A DECISION — ANY DECISION

1. **Get all the facts -**
   Each piece of information you have will help you make your choice. If there is something you need to know, keep asking until you have an answer.

2. **List your choices -**
   Write down as many choices as you can think of, even if they seem silly.

3. **List what you think is good about each choice -**
   There will probably be some things you like about each one.

4. **List what you don't like about each choice -**
   There will probably be some things about each that don't seem "perfect" to you.

5. **Pick the one choice that fits you best -**
   There is no "right" or "wrong" answer . . . only the answer that seems best for you *now.*

6. **Living with your choice -**
   Once you have made your choice, stick with it. You may have doubts once in a while. Believe in yourself. Accept your choice as being best for you both, right now. Don't worry about the past. Get on with your life.

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Living With Your Choice

You probably wonder how you will feel later on about the decisions you make now. That's a question no one can answer for you. It may be helpful, though, to hear from other young women who faced situations a lot like your own. We asked six young women to share their own experiences with you. Each of them was pregnant as a teenager. Each made a slightly different decision. One thing they have in common — they *all* finished their high school educations! And they all said they were glad!

BECKY

Becky was 17 years old at the time that she had her daughter. She was living at home, and she had the help and support of a very loving family. She did not marry the baby's father. She was a single mother for three years before she did get married. Her daughter now is 4 years old. She has a son that is four months old, and she is pregnant. She works as a beautician part time.

Q What was it like to raise a child alone for three years?

A “Well, I never really raised her alone. I had my mom and dad there to help me. It was more like my mom raised her, and I just came to visit. I went to school and then beauty school, and I was gone all the time. And then I started working.”

Q Did you ever get the feeling that she really wasn't your child, that she was almost like a little sister to you?

A “I always felt that way. And all my sisters and brothers feel like she's a sister. My daughter even called my mom ‘mama’ and me ‘Becky’.”

Q Did you and your mom ever have problems over who and how your child should be raised?

A “No, not really. My mom and I nearly always thought the same about how to raise her. I was just thankful I had my mom to help me.”

Q How did your folks feel about your dating?

A “They really encouraged me to go out. I had trouble dating for a while. It seemed like every guy thought because I already had a child, that I wouldn't care what I did with them. Well, it wasn't that way at all. You see, I thought getting pregnant was a mistake, and I didn't want to make any more. So, I often didn't go out with the same guy twice.”

Q After you married your husband, did your daughter have any trouble adjusting to her new daddy?

A “Yes, she went into a real deep depression. She wouldn't eat except when we'd go to my mom's house, and she always slept with us. In fact, the first night that we were home she said, ‘Ok, Daddy, you sleep in that room, and me and mom will sleep in the big bed.’ So you know, it was real hard for her to adjust. She missed my brothers and sisters.

“And it was very hard on my parents. They were real used to having her around, especially my dad. My mom even asked, ‘Why don't you just give her to me? We love her. She'd have a good home.’ But I just couldn't do it. I love her too much.”

Q Has she adjusted pretty well now?

A “Oh, yes. She still stays with my mom a lot, but she knows that our home is home now.”

Q Has she ever asked about her natural father or does she just assume that your husband is her real daddy?

A “Well, she knows that Nick isn't her father. She knows that he wasn't always around, but she's never asked. She's just too young to ask about that, I think.”

Q What do you plan to tell her when she does?

A “I really don't know. I just never thought about it. But she'll ask someday because she was in our wedding. She sees the pictures every day, and she looks at them. I don't know what I'm going to tell her when she asks. It's going to be hard.”

Q With a third child on the way, are you going to have money problems?

A “My husband is an apprentice plumber so he really doesn't make a lot of money. And he doesn't like for me to work, so it's hard. Money *is* a big problem!”

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LISA

Lisa was 14 when she got pregnant. She was the third daughter in her family that had become pregnant as a teen. She made the decision to release her baby for adoption. She has now graduated from high school. Her baby was born 19 months ago. She had a steady boyfriend at the time of her pregnancy, and she is still dating him. Lisa lives at home with her family.

Q Lisa, your decision to release your baby for adoption was different from the decisions that your sisters made for their pregnancies. Why did you make this choice?

A “Well, I just decided that would be best for all of us. I felt that the baby should go to someone that would give him what he needs and what he wants - maybe even spoil him occasionally! These are things which I couldn't do. Then I could finish high school and work for a while to save up my money and go to art school.”

Q How did your family react to this decision?

A “At first most of them wanted me to give it up. But then at the very end they all just started taking for granted that I was going to keep it without me saying anything at all. And I told them that I was not going to keep it, and they just had to accept it. They've stood behind me, even if they haven't always agreed with my choice.”

Q What did your boyfriend want you to do?

A “He wouldn't tell me what to do. I had a feeling that in a way he wanted me to keep it, yet he didn't want me to. He wanted me to keep it because he liked babies and it would be cute and all, but he didn't want me to keep it because of the responsibility. He really wasn't ready to get married. He told me he was glad that I had released the baby after it was all over with.”

Q Do you ever think about the baby now?

A “Not really. On his birthday I thought, 'Oh, yeah, it's his birthday today. He's a year old.' But, I don't really think about him very often. I know some girls do. They wonder where he is, how he's doing, and all, but I don't think it helps to wonder about him. I can guess what he looks like — blond hair, blue eyes, and a little pug nose. I just know he's making some couple real happy!”

Q Would you want his mother to tell him anything about you?

A “Yes, I want him to know that he was adopted. If he would find out accidentally, he'd probably be upset. I guess I'd like for him to know what I look like if he wants to know.”

Q Do you plan to get married and have a family someday?

A “Yes, but I'm not in a hurry. Sometimes I think I'd like to get married next year, but I don't know if my boyfriend will be ready. I would like to go to art school and then get a good job. When I get married, I know I'll want to wait a while before I have kids. I just want to be *ready* the next time I get pregnant.”

CONNIE

Connie was a sophomore in high school when she got pregnant. Her boyfriend was 18 years old and was a high school drop-out. She has been married for two years now and has a little girl who is 22 months old.

Q What are some of the problems that you've had being married as a teenager?

A “There have been a lot of changes. I've had to grow up very fast. I've had a lot more responsibilities — lost a lot of friends. We were both so young. We had a lot of adjustments to make — to the new baby, to each other.”

Q What was the biggest problem you had?

A “Money. There was never enough for all the things we needed. Our baby was sick for the first four months of her life. She was in and out of the hospital. My husband only made $100 a week. We wanted to live in an apartment, but we had to live with my folks because of the money.”

Q Were there any problems living with your folks?

A “Oh, yes! My mother was constantly fighting with me. She'd argue with me about the baby and about how to take care of her. She was always treating me like *I* was a baby, or she'd tell me to do more for my husband!

“Now, we get along pretty well. But, she still comes over to our house and says, 'The house is a wreck, what's the matter?' It really bugs me.”

Q What kind of problems did you have when you were still going to school and trying to be a mother and wife?

A “It was a mess. I had to get up at 4:00 a.m., take my husband to work at 5:00 a.m., come back, go to school at 7:00 a.m. I got out at 11:00 a.m., worked from 11:45 until 4:00 p.m., then went back to school from 6:00 to 9:00 p.m. I was *always* exhausted.”

Q Connie, you mentioned that there were some problems with friends. What do you mean by that?

A “They just kinda drifted away. I never saw them any more. Two of them gave me a baby shower. Some of my old friends showed up, but it was mostly just the family. I had things to do, though. I didn't have time to play their games any more.”

Q Now that you're out of school, who are your friends?

A “My friends are mostly the people that I work with or the girls who have been in the situation I was — who were pregnant and got married, or didn't get married, but have the same problems that I do.”

Q Are things better now?

A “Yes, I am saving my check so we can buy a home. We've been married two years now. I think we're over the hardest part. I think we'll make it!”

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JULIE

Julie was 16 at the time she found out about her pregnancy. When she was five months, she married Joe, the child's father. After a while, she had adjusted to the idea of raising a child and was looking forward to it.

Q Julie, you were married and were looking forward to raising a family. Then, things began to change. What happened?

A ❝ My husband didn't feel ready to be a father. We began to do some serious discussing and arguing on the subject of adoption. Joe was in favor of releasing the baby. At first, I was against the idea. The more we argued, the more I saw that, as a couple, we weren't ready to be parents. I realized we weren't emotionally capable and mature enough to raise a child properly. Finally, we agreed on putting the child up for adoption as soon as it was born.❞

Q That is an unusual decision for a married couple to make. How did your families feel about it?

A ❝ It was hard to tell our parents. Joe's parents did not agree at all and argued with us right up to the end. My parents didn't agree, either, but stood behind us in our decision.❞

Q Did you have much support from friends?

A ❝ Not really. Most people didn't feel it was right. Fortunately, most realized it was *our choice* to make and ours only.

❝ I won't say releasing her was easy. In fact, it was the hardest thing I have ever done! ❞

Q What about your marriage?

A ❝ About a year and a half after the baby was born, Joe and I got a divorce. The feeling that my decision was right was reinforced by that. I would never have wanted our child to face the hardships of a broken family.❞

Q It has been six years now since you released your baby. How do you feel about it now?

A ❝ I'm still happy and still have no regrets about my decision. Oh, there are moments here and there when I think deeply about her. I expect I'll always have those times.

❝ I feel confident she has good parents and a good life. I never met the couple who adopted her. But I know they were people who had waited for years to have a child and that they wanted her very much.❞

Q What are your own plans?

A ❝ I'm engaged to a wonderful man named Jim. I want children, but I will wait a few more years before starting a family.❞

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MELODY

Melody was a junior in high school when she got pregnant. She lived at home until the last couple of months of her pregnancy. Then, she decided to move into an apartment by herself. The father of her child was 15 years older than she was. He was a divorcee. He didn't stay in the picture for very long. Melody made the decision to keep her baby, and lived alone for the next 16 months. She is now married and has two children, Angel who is six, and David, age two.

Q Melody, what are some of the problems you faced being a single mother?

A “I think the biggest problem was being lonely, very lonely. I just stayed home with a tiny, screaming baby day after day after day.”

Q You didn't have any help with your baby?

A “No, not much. My mom and I didn't get along too well. We disagreed about how to take care of the baby or like how to give her a bath. Then she moved out of town.”

Q Did you have money problems?

A “Well, I was on welfare, and I got $118 a month. My apartment was $91.00, so there were often bills I just couldn't pay. I did try to get part time work, but they just subtracted that from my welfare check. So, it really didn't make any sense to try and work. There was no way to get ahead.”

Q How soon after you had your baby did you meet your husband?

A “Angel was nine months old. We dated about six months before we got married. I guess I was lucky — he really loves kids. Sometimes I wonder if the main reason I got married then was to give Angel a father.”

Q Did you have any fear that your husband would love your second child more because it was really his own child?

A “I sure did, and I told him about it. Finally, I decided it was all in my mind — like I was just looking for it. He has never shown more love for David than for Angel. And it would be easy for him, too, cause David is so much easier to handle than Angel.”

Q Your daughter is six years old now. Has she ever asked whether or not her daddy now is her real daddy? Do you have any plans to tell her that her father now is not her natural father?

A “Well, she's in our wedding pictures. She's looked at them and knows that she was in our wedding. I figured the question would arise sooner or later, but it's been about a year ago that David adopted her. We did tell her, and so she knows that she's adopted. She doesn't know anything about her natural father. I've never felt any reason to tell her because he's never seen her, never shown any interest in her at all. She just knows that we didn't have daddy when she was a baby. It was just she and I.”

Q Did you ever wonder after you decided to keep Angel whether you made the right decision or not?

A “I felt I made the right decision. I don't think I could have handled giving her up for adoption. I'm the type of person who would have always wondered what she was like, and what she was doing. I used to think that someone else could give her a better life and a better home, but I just couldn't give her up. I'm selfish, I guess. But it has all worked out for the best.”

TYONNA

Tyonna was 16 and a junior in high school when she found out she was pregnant. Her boyfriend was 19 and also a junior. Their families felt they should get married. They were married five years ago and have been divorced for eight months.

Q What kinds of problems did you face as a young married teen?

A “First of all, I didn't want to get married. I thought it was best that I didn't marry him 'cause I didn't think we would make it. But our parents thought it was best to give the child a name. I wanted to give her *my* name, but they didn't see it that way. We got married one afternoon very fast. We lived with his parents at first, then my folks. We fought a lot and finally I couldn't take it, so I moved out.”

Q What kind of problems were you having that made your marriage fail?

A “We never saw each other. He worked two jobs, a total of 15 hours every day. It's hard to have much of a marriage when you never see each other. Then he'd get jealous of other guys. I guess he thought I was playing around while he worked, but I wasn't. Things got better for a while, so we decided to have another baby. That was sure a mistake! The doctor told me that he thought that I was carrying a little boy. I thought this would make him happy, but it didn't. He said he didn't want anything but girls. Things just got worse and worse. He left me three days before I went into labor. It was a long, hard labor. I guess I was holding back because I didn't want to have a boy. Finally, I had the baby — no husband around — and it was a *girl!* ”

Q Did he change his mind and come back to you when he found out you had a girl?

A “He brought us home from the hospital and dropped us off like a piece of luggage. I'd get money in the mailbox, but I didn't see him for two months. Then I found out he was having an affair. I accepted him back because I thought maybe we could work things out. It didn't work, so I finally found a job when my baby was three months old. I felt like I had to be more independent. Beauty school came next and that's where I met some great single people.”

Q Have you dated much since you left your husband?

A “Oh, yes. I've dated a lot. I have even considered marriage. I miss it a lot. But, I don't think I'm ready yet. I need to find myself first.”

Q Has money been a problem?

A “Sure. My ex-husband doesn't pay any child support now. I even had to move back in with my folks for a while. Gosh, that was hard. I was used to doing what I wanted when I wanted to. My mother wanted me to date, but not too much because she had to stay home and babysit. Things are better now that I am out of beauty school. We have our own apartment and enough money to get by on.”

Q Do you think you'll ever get married again?

A “I'd like to, but I'm afraid to. I guess I don't want to get hurt again. I find that it is hard for me to let a guy get too close. I have it in the back of my mind, 'Somebody's going to hurt me'. I know I loved my husband, and I just don't want to be hurt again.”

Q What do you think you have learned from your first marriage that would make a second marriage more stable?

A “You have to have an honest relationship. That's something we never did have. We never talked our problems out. If I did talk and say something wrong, I'd get it across the face. And this time, no man is ever going to hit me again. You've just got to really be able to talk to each other, or it won't work.”

WHAT TO EXPECT IN THE HOSPITAL 9

If this is your first pregnancy, you will probably feel a little scared about going to the hospital. It is a good idea to visit the hospital sometime before you are in labor so you can see how things are set up.

Even though hospitals will have some differences, labor and delivery care is very much alike in most of them. In this section, we will take you on a "guided tour" to give you some idea of what you can expect to happen while you're there.

When to Go:

1. If this is your first baby, go to the hospital when your contractions are about *5 minutes apart*, last more than 40 seconds, and are regular for one hour. (If you have had a baby before, go when they are coming about 7-8 minutes apart.) . . .
   or
2. If your bag of water breaks . . .
   or
3. If you have any heavy bright red bleeding from the vagina.

(If you go to a private doctor, call him before you go to the hospital. He may want to examine you in his office to see if you are in true labor.)

Where to Go:

Some hospitals want you to check in at the main admitting desk. Others ask you to come to the emergency room. It is a good idea to check on this ahead of time!

What to Take:

1. Any identification: welfare card; health clinic card; insurance policy numbers, hospital number or census numbers
2. Toothbrush, toothpaste, comb, and make-up
3. Robe, slippers, nightgown
4. Bra and panties (nursing bra if you plan to breastfeed)
5. Sanitary belt (if you have it)

DO NOT WEAR ANY JEWELRY OR TAKE ANY MONEY WITH YOU TO THE HOSPITAL.

When You Go Home You Will Need:

1. Loose-fitting, comfortable clothes for you
2. T-shirt, diaper, and blanket, if you plan to keep the baby

HAVE SOMEONE BRING THESE THINGS TO YOU ON THE DAY YOU LEAVE THE HOSPITAL.

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Admitting:

From the admitting desk, you will be taken to the labor and delivery area. You may be asked to ride in a wheelchair to make sure you don't slip or fall. You may feel silly, but it's for your own safety.

Someone will check you to make sure you are in true labor. This exam is like the one you had on your first visit to the doctor. Remember to relax and breathe slowly. If you are in true labor, you will be asked to put on a hospital gown. A doctor or nurse will check your blood pressure, take your temperature, and listen to the baby's heartbeat. They will ask you many questions about your health, pregnancy, and labor so far.

At this time, you will probably be given a PREP. The hair will be shaved from around the opening of your vagina. This is done to keep the area clean and to keep hairs from getting in the stitches. You will probably also be given an ENEMA. A small amount of fluid will be put in your rectum (bottom) from a tube or plastic bottle. The enema does not hurt, but it will make you need to use the bathroom (have a bowel movement). This helps make more room for the baby to come out. The doctor or nurse may want to check you again soon.

Labor Room:

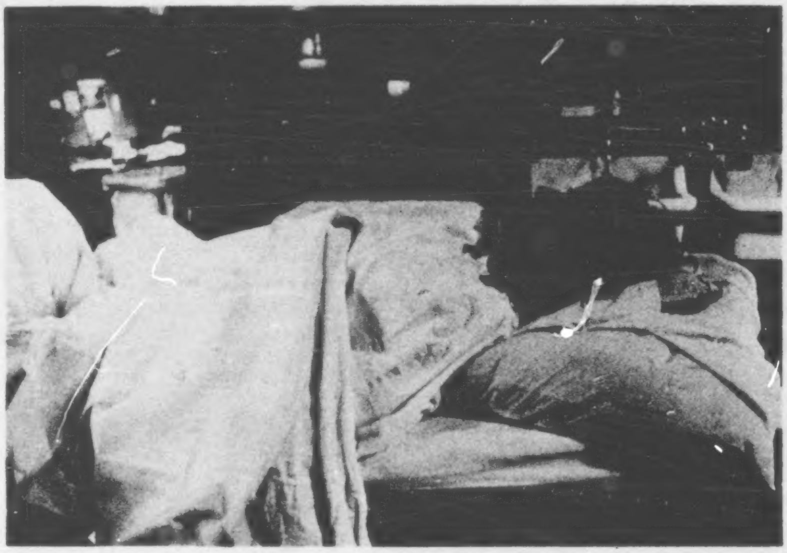
You will stay in a labor room until it is time for the baby to be born. These rooms are small and have everything you will need. While you are in labor, you will be allowed one visitor at a time. Be sure you choose someone you trust to be with you. This person can do more than just keep you company. He or she can help you with your breathing and relaxation, give you ice chips, and rub your back. All of these things will help make your labor more comfortable.

You should not eat or drink anything once you think you are in labor. This can make you sick to your stomach. Instead, you will be given an I.V. A needle will be put into a vein in the back of your hand or arm. This feels very much like a shot. Once it has been taped to you, you will no longer feel it. The I.V. is a sugar water feeding. It is important because it gives your body the energy and fluids you will need during labor. If you need other medicines, they may be given through this same tube.

Controlled breathing and relaxation will help you to be more comfortable during labor.

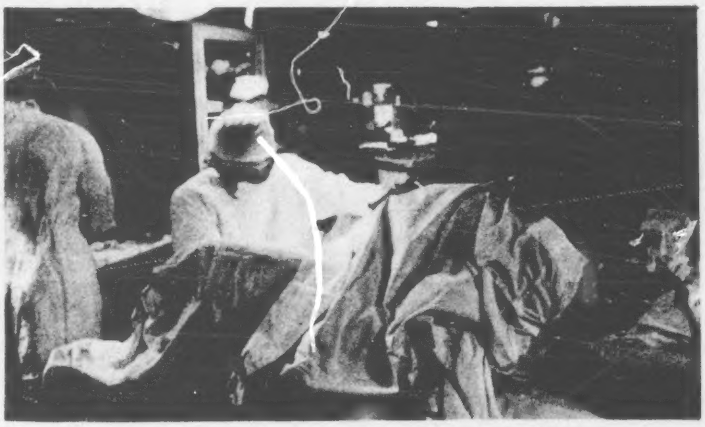
The doctor, nurse, or midwife should come in often to see how much the cervix has dilated (opened). They will put on clean rubber gloves each time and put two fingers in your vagina. This can be uncomfortable, so it is important that you relax and do your abdominal breathing during the exam. They will also want to check your blood pressure and pulse. They may use a machine called a fetal monitor to check the baby's heartbeat.

If your bag of water does not break by itself, the doctor may do this for you. There are no nerve endings in the bag, so this does not hurt you or the baby. He will put a long thin tube into your vagina. This tube has a little hook on the end to break the bag. You will feel the warm water flow out of the vagina. This fluid will leak out during the rest of your labor. There will be disposable pads on your bed that can be changed when they get wet.



Delivery Room:

When it is time for the baby to be born, you will be taken to the delivery room. You will be moved onto the delivery table. Your legs will be lifted into stirrups, like those in the doctor's office. The opening of the birth canal will be washed, and you will be covered with sterile sheets, called "drapes". It is important that you do not touch these with your hands. A mirror above the table can be adjusted if you want to watch the baby being born.

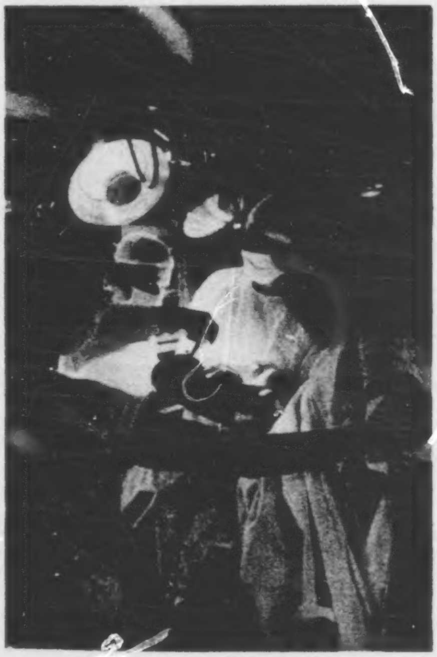


The doctor will tell you when to help by pushing. While you are pushing, he may make a small cut to make the opening larger for the baby's head to come through. This EPISIOTOMY is done to keep your skin from tearing when the baby comes out. The cut will be sewn up with a few stitches and will heal quickly. (A tear does not heal as well and is more painful.) You will not need to have the stitches removed. They will dissolve into the skin as the cut heals.

When the baby is born, you may hear him begin to cry. This is a good sign. It means that he is beginning to breathe on his own. The cord will be clamped shut and cut. Neither you nor the baby can feel this. The baby will be carefully checked, and the mucus will be taken out of his mouth to help him breathe.

You may be able to see and hold the baby if you want. Some mothers are being allowed to nurse their babies right after they are born. These first few minutes are very important to both you and the baby. Babies are wide awake at this time and enjoy being close to their mothers. Check with your doctor ahead of time if you'd like to hold your baby soon after birth.

After a few minutes and a few more contractions, the placenta will come out. The doctor may ask you to help push, or he may press on your abdomen. This is the end of your labor. At this time, you may be given some medicine to help the uterus tighten up. This tightening does not feel like labor.



Birth sequence courtesy of Michele Zackheim.

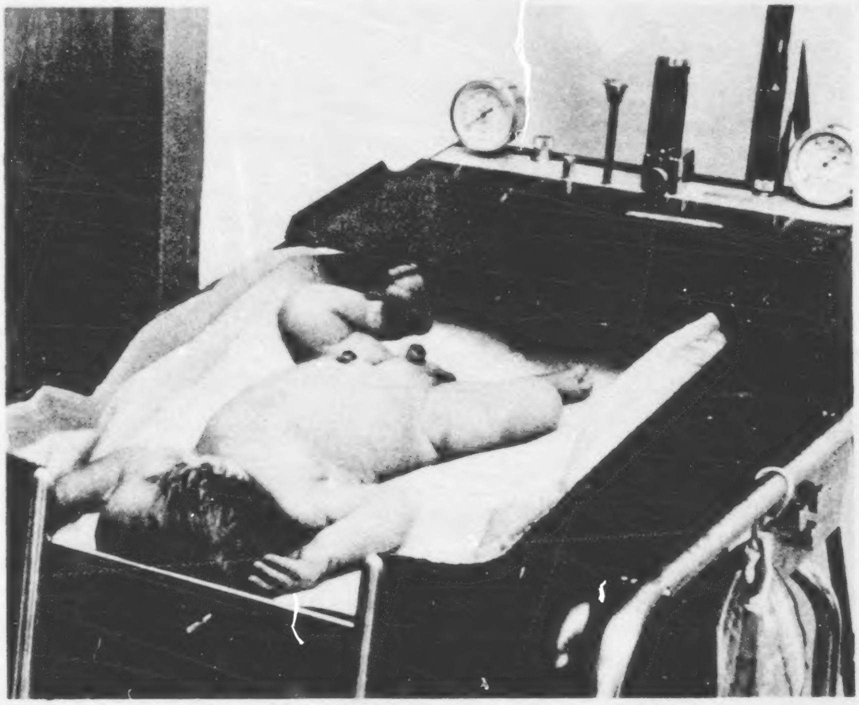


Photo courtesy of M & I Project, U.N.M.

Care of the Baby:

You and the baby will be given identification bands that are alike. The baby will be placed on a special bed that will keep him warm. The doctor, midwife, or nurse will check him carefully to make sure he is all right. He will be weighed. Drops will be put in his eyes to keep them from getting infected. From here, the baby will go to the nursery.

Recovery Room:

When you leave the delivery room, you may be taken back to your labor room or to a recovery area. For the first hour after delivery, the nurses will watch you carefully. They will take your blood pressure and pulse often. You may be given an ice pack to make your stitches feel better and cut down on swelling. They will check your pad for bleeding and change it when needed. Your only job now is to rest! You can also eat if you want to.

Your uterus will be tightening up during this time. The nurses may massage (rub) your abdomen to make sure that your uterus stays hard. This helps cut down the amount of bleeding. The nurses may show you how to massage your own uterus. When you do, you will notice that it feels like a tight hard knot underneath your belly button.

Postpartal Stay:

You will stay in the hospital for one to three days after delivery. During this time, you can expect to be kept busy. Be sure to have someone with you the first time you get out of bed, because you may feel faint. You can take a shower as soon as you feel steady enough. You will also take "sitz" baths. A sitz is a small tub that is filled with warm water. Sitting in the water keeps your stitches clean and feels good.

You will need to rest as much as you can. Getting up and walking around will help you get your strength back. If the hospital offers classes in baby care, it is a good idea to attend. You will enjoy meeting other new mothers and learning how to take care of your baby. The nurses are there to help you. Be sure to ask them any questions you may have.

Most hospitals have special visiting hours. They often limit the number of visitors you can have. Too many visitors can be tiring for you. Your friends and family can see the baby through the nursery window.

While you are in the hospital, spend as much time with your baby as you can. It's good for mother and baby to be together so they can get to know each other. Touch your baby and hold him close. Each time you do, you will learn more about the way he looks and acts. The more you are together, the closer you will feel. He may seem a little sleepy and have a hard time sucking during these early days. This is normal. You can wake him up by bouncing him *gently* and tickling his feet.

If you are releasing the baby for adoption, you will be given the choice of whether or not to see him. Some girls say they enjoy caring for the baby in the hospital. Others would rather not see him at all. This choice is completely yours. Do what you feel is best for you. A social worker will talk to you about signing the adoption papers.

If you are uncertain about your decision, your social worker will understand and will not pressure you. The first few days after you deliver you may feel very mixed up. You will be able to think more clearly when you get home. Give yourself time. Then you can make a decision you can live with because you thought carefully about what was best for you and your baby.

Birth Certificate:

All births must be registered with the state. While you are in the hospital, you will be given a form to fill out for the birth certificate. You will be asked to fill in the baby's name, your name, and the father's name. The doctor will fill in the part about the baby's birth. Check the form carefully to make sure everything on it is correct. If you want a copy of the birth certificate, you can get one by writing to your State Department of Vital Statistics in the state capitol. Even though it may cost a little money, it is important for you to have one. Your child will need it many times during his life, so keep it in a safe place.

Circumcision:

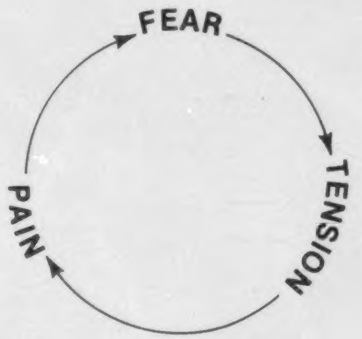
If your child is a boy, you will need to decide whether or not to have him circumcised. CIRCUMCISION is the removal of the loose fold of skin that covers the end of the penis. It was once believed that circumcision was important to prevent infections. It is not needed if the penis is carefully cleaned. The child's father, other men in the family, or the doctor can help you decide. If you have this done, follow the doctor's directions for care of the penis while it heals.

Photo courtesy of M & I Project, U.N.M.

BEING COMFORTABLE DURING LABOR 10

Natural Childbirth Means Prepared Childbirth

You may have heard that some women go through "natural childbirth" to have a baby. What does this mean to you? Does it mean that you can't have anything to take away pain while you're in labor? No! "Natural childbirth" really means "prepared childbirth". If you are prepared, you have learned what labor is like and how you can help. All childbirth classes teach you exercises and ways to relax. There are special ways you learn to breathe that can help you with labor. The main point of all "natural childbirth" classes is to help you have a happier, healthier delivery.



Fear - Tension - Pain Cycle

You may wonder how breathing and relaxation can help. Much of the pain of labor is caused by fear . . . you are scared and afraid because you don't know what's going to happen. When you get scared, your body tightens up and you feel tense. Tight, tense muscles cause pain . . . and it goes on and on . . .

Breaking the Cycle

When you learn about labor and delivery, then you won't be so scared about what's going to happen. If you learn how to relax and how to breathe with contractions, then your muscles will not be so tense. When you feel happy and relaxed, you won't feel as much discomfort. If you don't feel much pain, you won't need much medicine. Then you will be more awake and able to help when the baby comes. Sometimes women need a little medicine to help them relax! This is O.K.! The doctor or nurse can help you decide if you need something for pain.

Kinds of Classes

There are several kinds of childbirth classes. You may have heard of Lamaze or Bradley. Each one teaches breathing exercises in a little different way. The exercises that are in the special booklet will also prepare you for labor and delivery. *Practice* is an important part of all childbirth classes. Just as athletes ("jocks") spend hours training for a big event, you should too! Getting in shape for childbirth can be a lot of fun!

The Labor Coach

It is helpful to have someone with you during labor to give you help and support. It is important that this person be someone you like and trust. This might be your husband, boyfriend, mother or other friend or relative. The person who stays with you in labor is often called a "coach". Just as a coach gives help and support to the players on his team, your coach will be there to encourage you through labor. He or she will learn how to help you breathe and relax. Being a coach isn't easy, so your coach will need to learn as much about labor and delivery as you do. It is a good idea for this person to read this book. If classes are available in the area where you live, it is important that you go together. Check with your doctor or hospital to find out where these classes are given.

Your "coach" can help you time contractions.

It is important to practice what you learn in childbirth classes with the person who will be with you in labor.

Analgesia and Anesthesia

"Will they give me anything for pain?" is a question most women ask. There are different kinds of medicine that can be used if you need help. If you have reasons for not wanting any, *talk to your doctor before you go into labor*.

Analgesia is a drug that is given to take away some of the discomfort of labor. It is usually given as a "shot" when you are in good, active labor. It will not take away all the pain. It will help you to relax and you may feel sleepy. If you are having trouble relaxing or breathing with contractions, talk with the nurse or doctor. Together, you can decide what's best for you and the baby.

Anesthesia is a drug given to take away all feeling in your body, or a part of it. If you have ever had a tooth pulled or had stitches for a cut, you have had a kind of anesthesia. The drug made that part of your body feel numb, and you couldn't feel any pain. Anesthesia is used in labor and delivery to take away the discomfort of childbirth. There are different kinds. Any anesthesia does get into the baby's blood.

General - This kind, usually gas, puts you to sleep. Most doctors would rather not use it because of the possible danger to the baby. With general anesthesia, the baby may be a little sleepy when he's born. Also, gas *can* make you vomit. This can be dangerous if you are asleep. Most women like to be awake when their babies are born.

Regional - This kind puts an area or region of your body to sleep, but *you* are awake. Most doctors like this kind because you feel no pain and can help with delivery. Also, it is less dangerous to the baby. There are three kinds of regional anesthesia:

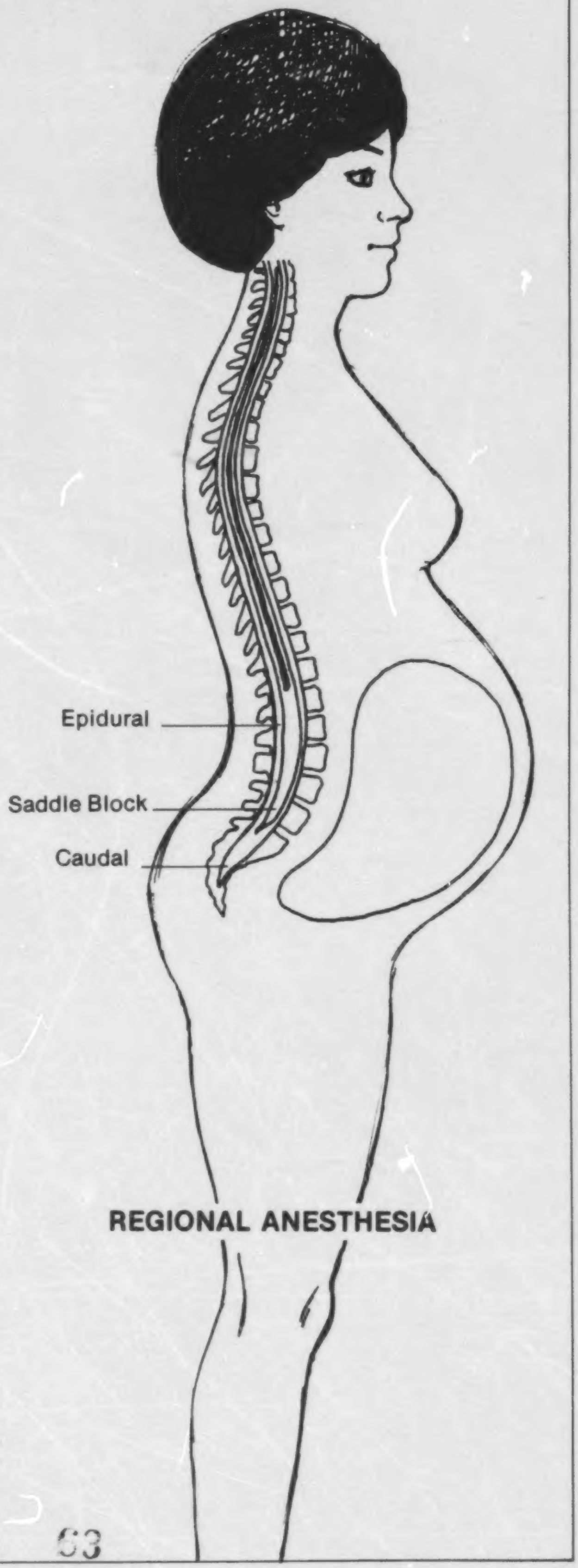
(1) *Saddle Block or Spinal* - This is a shot given in your back (see drawing) right before the baby is born. You won't feel anything from your waist to your toes. You will need help in "pushing" the baby out since you can't feel anything. FORCEPS may be used at this time. Forceps are metal instruments that help the doctor lift the baby's head out of the birth canal. If you have a saddle block, most doctors will want you to lie flat on your back for a few hours after delivery. Some people are afraid they will be paralyzed (can't walk) if they have a spinal. *This is not true!*

(2) *Epidural or Caudal* - These two are very much alike. They are given in the lower back (see drawing) during the hardest part of your labor. A small tube can be left in place for more medicine if it is needed. The epidural takes away the feeling from your waist to your thighs. Many doctors like to use it because it can be given sooner than the saddle block. Some hospitals don't use epidurals because it takes a specially trained doctor to give them.

(3) *Nerve Blocks* - There are two kinds of nerve blocks.

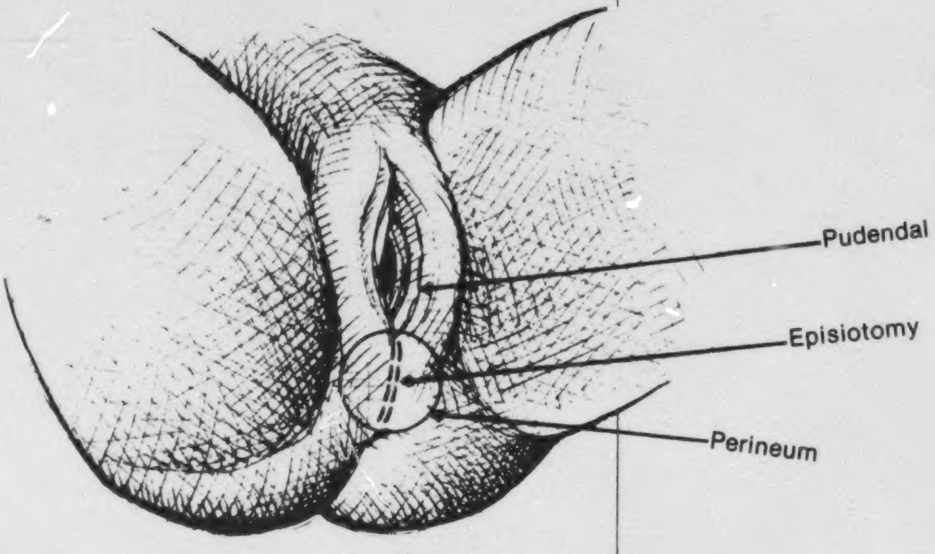
  (a) *Paracervical* - The anesthetic can be put into the cervix when it is at least four centimeters dilated. It eases the pain that is due to the opening up of the cervix. It may be given again in an hour or two if needed. It does not take away the feeling in the birth canal.

  (b) *Pudendal* - This is given inside the opening of the birth canal when you are ready to deliver. You will have less feeling in the PERINEUM where the episiotomy (cut) will be made. The perineum is the area between your vagina and rectum (see drawing on next page). The pudendal does not take away the feeling of contractions. It's often used when a mother wants "natural childbirth".



REGIONAL ANESTHESIA

Local - A shot may be given in the perineum to numb the place where the doctor will make the cut for the episiotomy.



At this point, you may not know what kind of analgesia or anesthesia you want. You may not want to make a choice about this. That's O.K., too! Your doctor can decide what he thinks is best for you and the baby. If you do want to help in making the choice, talk to your doctor before you go into labor. He can answer your questions and tell you what he thinks. The kind of anesthesia you will have will depend on . . .

. . . how prepared you are for labor
. . . your beliefs about childbirth
. . . how you react to pain
. . . your health before and during labor
. . . the baby's health during labor
. . . how quickly your labor goes
. . . what kinds the hospital uses
. . . what your doctor suggests

GIVE IT SOME THOUGHT!

LABOR AND DELIVERY

11

"Labor sometimes seems so far away and unreal. It's almost a feeling that I never will go into labor. Then, at other times it seems too close. Labor doesn't scare me, but it does make me a little nervous to think about being a mother. Being pregnant has changed my life, but once the baby comes almost nothing will be the same."

"Of course, I'm kind of scared. I can't wait to get it over with, but I guess every mother gets scared the first time."

"Sometimes when I hear other girls talking about labor I do get a little scared. But I do look forward to going into labor. Then I'll have my little baby!"

What do you think of when you think of the word "labor"?

Fear? Pain? The end of pregnancy? Having the baby? Work? Labor was well named, for it *is* work, *hard work*! The more you learn about labor and what you can do to make it easier, the more you will look forward to it. It can be an exciting time for you!

Labor is different for each woman. First labors are often the longest, with the average time being between eight and sixteen hours. Your labor may be shorter or longer. This depends on how your body works and how well prepared you are.

How will I know when I am in labor?

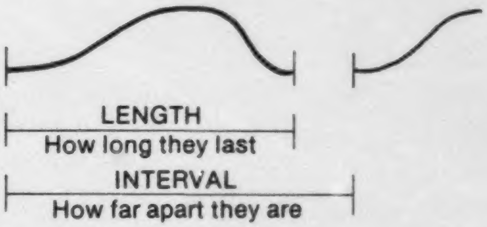
There are certain signs that will help you to know. You may or may not have all of them.

1. *Bloody show* - This pink or light red discharge from your vagina is the plug of mucus that blocked your cervix during pregnancy. The "show" can come a day or so before labor begins. If you have any bright red bleeding, call your doctor or clinic.

2. *Breaking of the bag of water* - You may have a sudden gush of water from your vagina or it may be a trickle. *If the bag of wa[illegible]ks, go to the hospital or call your doctor!* Often the bag of water does not break until you are well into labor.

3. *Contractions* - Contractions are the tightening of the muscles of the uterus. Their purpose is to open the cervix so the baby can be born. You may feel them begin in your back as a backache. This tightness may then move around to the front. Some women say that early contractions feel like cramps or gas pains. As labor goes on, the contractions get stronger, come more often, and last longer.

How do I time contractions?



The tightening of the contraction begins slowly and gets stronger until it reaches a peak. Then it quickly goes away. It is like a roller-coaster ride . . . a slow start and a fast finish! You will need to know how to time contractions so you can tell the doctor. When you first feel the tightening, write down the time. A watch or clock with a second hand would be helpful. Watch the second hand until you no longer feel the tightness. That's the LENGTH of the contraction. They last only 20-30 seconds when they first begin. Between contractions, there is no pain or discomfort. When the next one begins, write down the time. After several contractions, you will begin to see a pattern in how often they come. From the beginning of one contraction to the beginning of the next is the INTERVAL, or how far apart they are. Your early contractions may be 10-20 minutes apart.

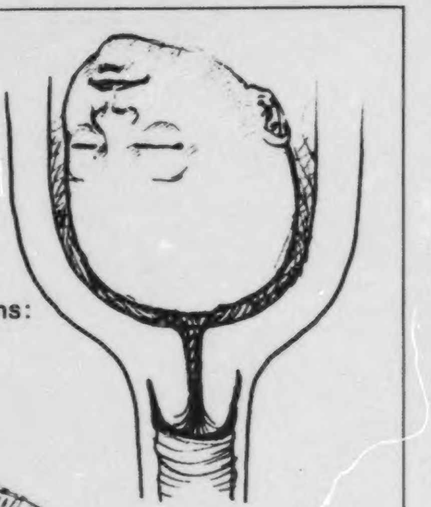
How will I know if it is false labor or true labor?

Sometimes it is hard to tell! Below is a chart that may help you to decide if it is true labor. If you aren't sure, go to your doctor or hospital. The doctor will do a vaginal exam. If it's true labor, the cervix will be thinning out (EFFACING) and opening up (DILATING).

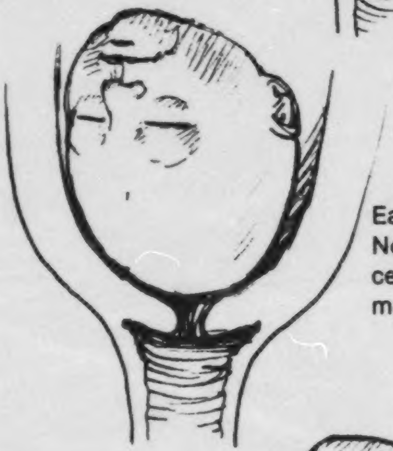
TRUE LABOR	FALSE LABOR
1. Usually begins in the back and moves to the front	1. Usually felt the strongest in the front
2. Regular pattern with contractions getting closer together and lasting longer	2. No regular pattern over a long period of time; may just stop altogether
3. Walking around makes the contractions stronger.	3. The contractions may let up if you walk around.

What happens during labor?

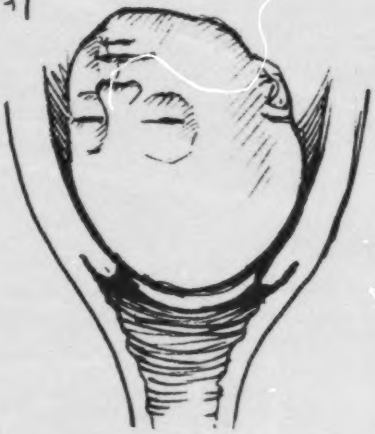
Labor is divided into three stages. *The first stage begins with your first true labor contraction and ends when the cervix has opened enough to let the baby's head pass through.* Two things have to happen to the cervix: (1) it must thin out (EFFACEMENT), and (2) it must open up (DILATION). During pregnancy, the cervix is long, thick, and closed. The doctor watches for changes in the cervix during your last month. It becomes softer and thinner as you near delivery. He calls this a "ripe" cervix. The cervix may be completely thinned out by the time you go into labor. The opening up of the cervix is measured in centimeters. By the end of the first stage of labor, your cervix will be opened to ten centimeters (4 inches).



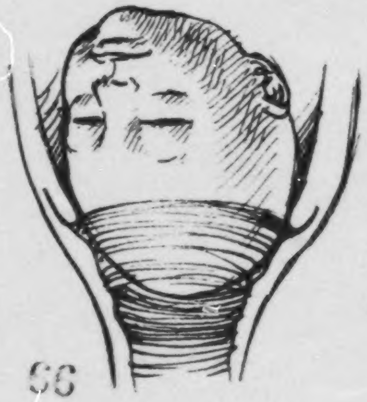
Before labor begins: Cervix is long, thick and closed.



Early labor: Notice how the cervix has almost disappeared.

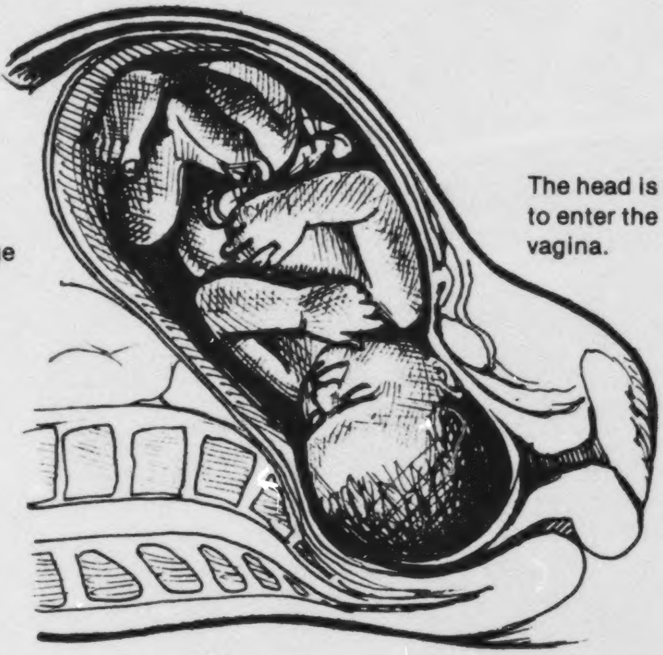


Middle labor: The cervix has opened up 6-8 centimeters.



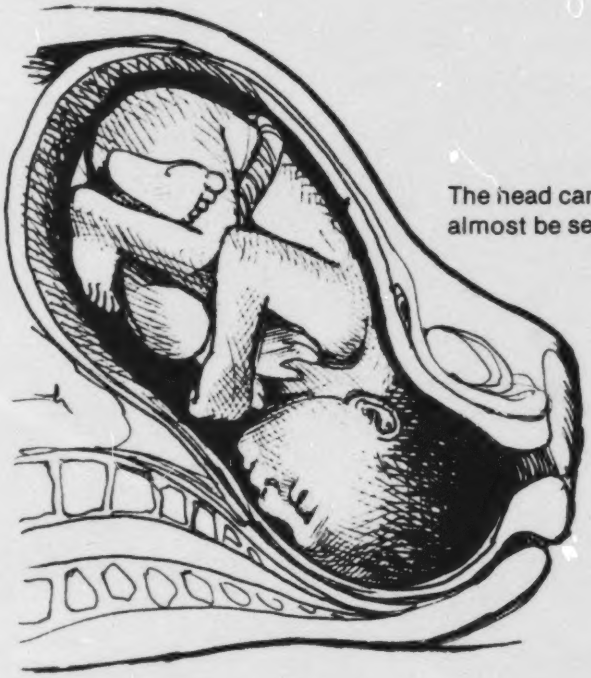
End of first stage: The cervix is completely opened up. The head can now come through.

The second stage of labor is the delivery stage. It begins when your cervix is completely opened up and ends when the baby is born. You will be able to help by pushing to bring the baby down and out. The baby *does not* push himself out! You will go to the delivery room when the top (crown) of his head can be seen at the opening of your vagina.



TRANSITION
End of the first stage

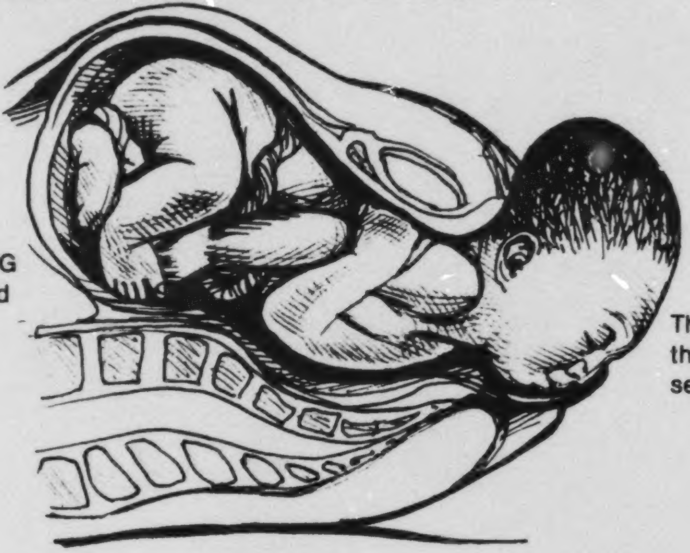
The head is ready
to enter the
vagina.



BEFORE CROWNING
Middle of second stage

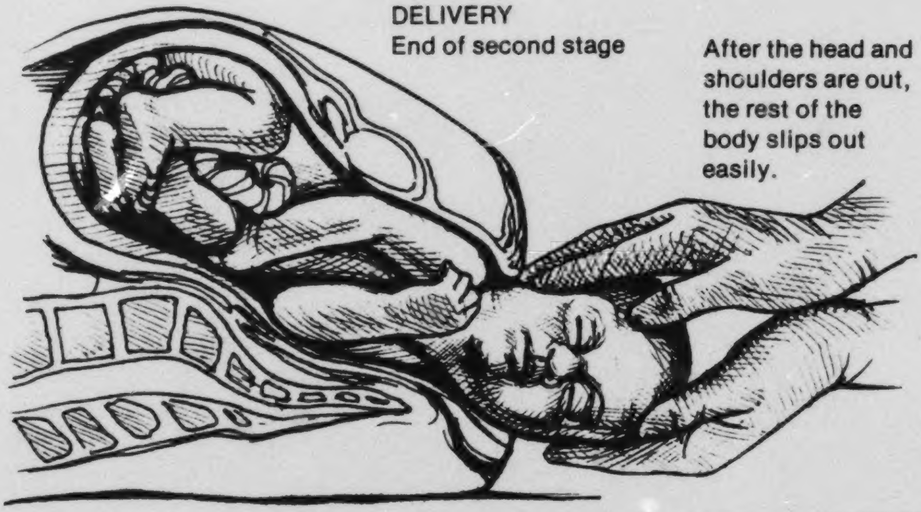
The head can
almost be seen.

CROWNING
Top of head



The crown of the head is seen.

DELIVERY
End of second stage

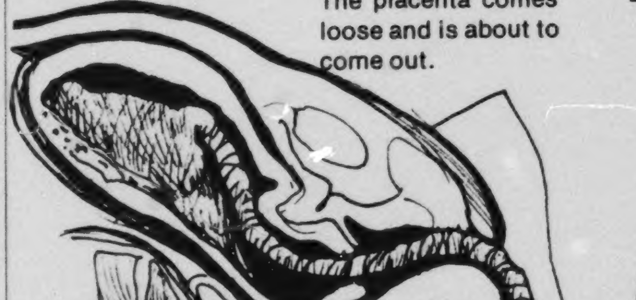


After the head and shoulders are out, the rest of the body slips out easily.

The third stage of labor is the delivery of the placenta (afterbirth). It begins as soon as the baby is born and lasts until the placenta separates from the wall of the uterus and comes out.

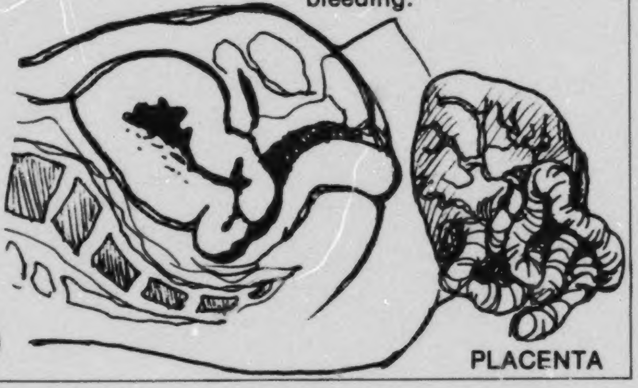
THIRD STAGE

The placenta comes loose and is about to come out.



END OF THE THIRD STAGE

The uterus tightens quickly to prevent bleeding.



How will I feel and what can I do to help with labor?

WHAT'S HAPPENING	HOW YOU FEEL	WHAT TO DO
FIRST STAGE: *Effacement and Dilation of the Cervix* Cervix is dilating 0-3 centimeters. Lasts: 6-8 hours - longest part of labor.	Chances are you will feel excited when you think you are in labor. You may not be too uncomfortable. Some women have gas pains and have to go to the bathroom a lot. You may even have lots of energy! The contractions are coming 5-10 minutes apart and last 20-45 seconds.	Do what you feel like doing. You can go to school, to a movie, or watch T.V. Try to keep your mind busy so the time will go faster. This is not a good time to use a lot of energy cleaning the house! Walking will help your labor go faster. It's best not to eat any food once labor has started. It will not digest during labor and you may vomit.
Cervix is dilating 4-7 centimeters. Lasts: Several hours, but shorter than first part.	You will feel more serious now and will think about each contraction. Your contractions are stronger and may be very uncomfortable. You may want some medicine to help you relax. The contractions are coming every 2-5 minutes and are lasting 45 seconds to one minute.	Relax! The abdominal breathing you have been practicing will help. You may be more comfortable lying on your side or with your back propped up. Ice chips and a damp washcloth may help. A back rub may feel good.
Transition: Cervix is dilating 8-10 centimeters. Lasts: 30 minutes to 1½ hours. Contractions last up to a minute and a half and will come every minute or two.	Your contractions are the longest and strongest now. You may have trouble relaxing. Between contractions, you may sleep, since you have no pain then. You may feel scared, but remember it isn't much longer until it is over.	You may want to try the fast, shallow breathing now. When you feel the urge to push, pant until the doctor or nurse tells you to push.
The baby's head is starting to push through the open cervix.	At the end of the first stage, you may feel like pushing or like you have to go to the bathroom. You may hiccough, burp, or vomit; your legs may shake. You may be very grouchy and may order everyone to leave you alone!	As soon as the doctor thinks you are ready, he will have you bear down and push to help move the baby down the birth canal. He may want you to pant if the cervix isn't completely dilated.
SECOND STAGE: *Delivery of Baby* The baby moves down the birth canal and is born. Contractions come every few minutes and last a minute or more. Lasts: 20 minutes to one hour.	You will feel more awake now. The hardest part of labor is over. The contractions are strong, but they shouldn't hurt as much as they did during transition. The need to push may be strong if you haven't had any anesthesia. Many women think it feels good to push.	Now you can really help! The doctor will give you directions to either push or pant. Try to do as he says to make your delivery as fast and safe as possible. Relax between contractions.

WHAT'S HAPPENING	HOW YOU FEEL	WHAT TO DO
THIRD STAGE: *Delivery of Placenta* The placenta separates from the wall of the uterus and comes out. Lasts: 15-30 minutes.	You may feel another contraction or two. Chances are you will be so glad that labor is over that you won't notice anything. You may feel happy and tired.	Relax and do as the doctor asks. You may want to watch the nurse take care of the baby.
FOURTH STAGE: First Hour After Delivery The uterus contracts to the size of a grapefruit and returns to the level of your belly button.	You may feel very tired and want to sleep. Some women are too excited to sleep! You may be very hungry. Your legs may shake. You may have tears, even if you are very happy.	Rest! The nurse may teach you how to massage (rub) your uterus to keep it firm. She will want you to urinate as soon as you can.

“Labor really wasn't what I had expected it to be. I guess I shouldn't have listened to people, because everybody's labor is different. Mine wasn't as bad as I had expected it to be. Boy, does breathing really help! Without that, you have really got your work cut out for you!”

“I didn't practice the breathing exercises because I didn't think labor would be that hard. When the contractions got real strong, I couldn't relax any more. I was really scared! Then a nurse came in and helped me with my breathing. That helped, but I sure wished I had known what I was doing!”

“My friend was with me during labor. It really helped having my friend coach me! I was sure glad we had practiced together before I went into labor.”

When Things Don't Go As Expected - Cesarean Section

A Cesarean section is another way a baby can be born. Sometimes a woman can't have her baby through the birth canal. When this happens, the doctor makes an incision (cut) in the woman's abdomen and uterus and lifts the baby out. The woman does not feel the cut because she gets some kind of anesthesia to take away the feeling. Sometimes a woman is "put to sleep" with gas. Other women get a "spinal" which numbs the place where the cut is made. If you have a Cesarean, you may get to help the doctor decide which kind of anesthesia you want. If you have a spinal, you will be awake to see the baby when it is born.

You may feel scared and disappointed about having a Cesarean. If you have one, it's because the doctor thinks it is the safest way for you and the baby. You will still be a good mother and soon will be feeling fine. (See page 73 for care after a Cesarean Birth.)

AFTER THE BABY'S BORN..NOW WHAT? 12

After you have had the baby, there are many changes that take place in your body and in your life! The first six weeks are called the *postpartum* (after delivery) *period*. It takes this long for your body to get used to not being pregnant. You may have many questions about yourself and your care. Many of these questions will be answered here. Be sure to ask your doctor if there are other things you want to know.

How soon will I be able to wear my regular clothes again?

Two things must happen before your regular clothes will fit. First, you must lose weight. Second, you must firm up those loose tummy muscles! You may lose 12-15 pounds in the first few days and another 10-15 pounds in the next six weeks. The amount you lose depends on how much you gained during pregnancy and how much of that weight was water. You will begin to get rid of the extra water soon after delivery. You may be very surprised by how much you sweat and go to the bathroom.

If you had a flat tummy before you were pregnant, the muscles will tighten up quickly if you exercise and eat well. There are some exercises you can begin in the hospital if you had a normal labor and delivery. (See exercise booklet.) If you try hard, you will be fastening those jeans again very soon.

What should I eat?

Stay with the same good eating habits you started during pregnancy. Most women are surprised how their appetites change. You may have thought about food all of the time while you were pregnant. Now you may not even want to eat very much. It's not a good idea to eat sweets, desserts, and other "junk foods". They just add pounds. Foods high in protein and vitamins are really important to help your body get back to normal. Don't skip meals to lose weight quickly. You'll only be hurting yourself!

If you are breastfeeding, you will need to eat plenty of good food and drink lots of liquids. This is important so you will have enough good milk for the baby to grow on. (See booklet on breastfeeding.)

Tell me about the changes in my uterus.

You will be able to feel your uterus in your abdomen for a few days. It feels like a firm grapefruit. The day after you deliver, it should be just below your belly button. Each day it gets smaller and moves down in your pelvis. After ten days, it should be low enough that you can no longer feel it. The return of your uterus to its normal size is called INVOLUTION.

Will it hurt as it gets smaller?

Some women have cramps called "afterpains" for a few days. You may not have any at all. Afterpains are more common in women who have had lots of babies. Women who breastfeed sometimes feel a little cramping the first few days when the baby nurses. This is good because it means the uterus is getting smaller. That's why mothers who breastfeed get back in shape faster than mothers who bottle feed.

Don't be disappointed if you can't wear your regular clothes home from the hospital. It may be a while before you can fasten those jeans!

Why do I have a discharge and how long will it last?

Inside your uterus is an open wound where the placenta grew. The uterus is warm, dark, and wet inside, so it takes this wound a long time to heal. It can't make a scab like a wound on the outside that has air to help it dry. The bleeding you have is from this wound and is called LOCHIA. It goes from bright red to pinkish brown. Then it turns a yellow color as it slowly heals.

Some girls are healed in three weeks. Others take six weeks for the discharge to go away. The important thing is to keep your perineum as clean as you can. This means washing daily. Also, wipe from front to back when you use the bathroom. *Don't put anything in your vagina until the bleeding is gone — no tampons or sex!*

When will I have my first period?

This is also different from woman to woman. If you aren't breastfeeding, you may have a period about six to twelve weeks after having the baby. If you are breastfeeding, you may not have a period until you stop nursing.

When can I have sex?

Most doctors want you to wait until after your six-week check-up. Many couples don't wait that long. If all of your bleeding has stopped after three or four weeks, it may be safe for you to have sex. You can ask your doctor. *Remember, you can get pregnant again!* This is the time to think about birth control. Do you want to take a chance on getting pregnant again right away? You should not get pregnant if you use foam and your partner uses a condom (rubber). (See Chapter 15.)

Can I get pregnant even if I haven't had a period?

YES! Your ovary can make an egg at any time after you have had the baby.

How will my breasts change after delivery?

It depends on how the baby will be fed. If you don't plan to breastfeed, you may be given a shot in the delivery room or pills to take. This helps to keep your breasts from making milk. Your breasts should return to normal size within a month or two. Some changes will not go away. The nipples will always be a little darker than before. Your breasts may not be as firm. If you breastfeed, your breasts will stay larger until you are no longer breastfeeding. *Breastfeeding does not cause breasts to sag!*

When does the milk come in if I breastfeed? Will it hurt?

For the first two or three days after delivery, your breasts will make COLOSTRUM. This is the sticky, yellow fluid you had during pregnancy. It is a perfect food for the baby. It gives him protection from some diseases. About the third day, your breasts will start making milk. You will know when this happens. Your breasts will become larger and they may hurt. This is called ENGORGEMENT. It means your breasts are starting to fill with milk. You may be uncomfortable for 24-48 hours. Once the breasts get used to making milk, they won't hurt. Some doctors believe your breasts will feel better if you nurse your baby often starting soon after delivery. Read the booklet on breastfeeding to find out more about this.

Should I wear a bra?

Yes, it's a good idea. This helps the breasts to look better as they go down in size. If you are breastfeeding, you will be more comfortable wearing a nursing bra day and night for a while. If you're not breastfeeding, then wear a well-fitting bra during the day.

What about my stitches?

Most women have a few stitches after delivery. These stitches will go away in a week or two. They don't have to be taken out. Your bottom will be sore for a while as the skin heals. Continue sitting in a pan or tub of warm water once or twice a day. You may find that sitting on a pillow helps.

If you have hemorrhoids, they may be sore for a while. Usually they will get smaller and may even go away. Sitting in warm water will make them feel better.

Will I break my stitches if I push too hard when I use the bathroom?

This is a common fear. Before you leave the hospital, the doctor may give you something to make it easier for you to have a bowel movement. It may hurt a little the first few times you go. Don't worry about the stitches coming out! Drink lots of water and eat fresh fruits and vegetables. Try to have a bowel movement every day or two. Not using the bathroom can make your stitches hurt more.

How soon can I take a bath and wash my hair?

If you want, you can take a shower and wash your hair the day after you have a baby! Being clean not only keeps you healthy, it can also make you feel much better. Some people believe that you should not bathe or wash your hair for forty days. Doctors don't think that bathing can harm you. However, if you would feel better not taking a bath, *be sure to wash yourself carefully each day with soap and warm water.*

Why am I so tired?

Even though having a baby is a normal, healthy thing, labor is a lot of work! Your body needs plenty of rest to get back to normal. If you are up a few times at night with the baby, you will need to make up the lost sleep. Rest every time you can! Go to bed early and sleep as late as you can. Naps during the day will also help you feel better. Many women feel good and try to do too much too soon. If you do too much, it will take longer for you to get back to normal.

When can I go out of the house?

If the weather is nice, you can take a walk outside a day or two after you go home. Getting away for a while often can make you feel better. You can go back to school two weeks after delivery if everything is normal.

What is the post-partum check-up?

You will be given an appointment to go to the doctor about four to six weeks after you have the baby. The doctor will give you an exam to see if your body has gone back to normal. He will check the female organs. He may talk to you about birth control. (See Chapter 15.) This is a good time to ask any questions you may have. Remember: GO FOR THIS CHECK-UP. *It's important for good health!*

How is my care different if I have had a Cesarean birth?

You will be in the hospital longer because a Cesarean is an operation. But, much of your care is the same. About 8 hours after the baby's birth, the nurse will want you to get up and walk. You may not want to do it, but the nurse will help you. It will hurt for a while, but it is important because it helps you to heal faster. It is a good idea to put your hands over your tummy to give it support when you get up.

The incision or cut will hurt for a few days. Then it will feel sore and tender to touch. It will begin to itch as it heals. It should be pretty well healed in two or three weeks. The redness will fade, and the scar won't look bad after a few months.

You will get sugar water feedings through an I.V. for a day or two. The doctor will not want you to eat anything solid for a while. This helps to prevent "gas pains" that you may get on the second or third day. If you get gas pains, tell the doctor. He can give you something to help them.

The nurse may ask you to cough and deep breathe for a day or two. This helps to get more air into your lungs. Remember to support your tummy with your hands if these things feel uncomfortable for you to do.

The doctor will tell you when you can take a shower. Usually this is after the stitches have been taken out. Washing off with soap and water each day will make you feel fresher.

You will have a discharge from your vagina like women who have babies from the birth canal. The difference is that your "bottom" won't be sore. Your stitches and soreness are in your tummy instead!

Many mothers who have Cesareans also breastfeed their babies. You can, too! It takes a little work for a few days because you are sore, but you _can_ do it.

HELPFUL HINTS AFTER A CESAREAN BIRTH:

— Rest for at least two weeks
— No heavy lifting for two weeks
— Avoid long climbs up and down stairs
— Get help for cooking, cleaning, and washing
— Wear loose clothing to protect your tummy
— No sex until your incision is healed
— No exercise for 3 to 6 weeks
— Do not drive a car for 2 weeks
— Enjoy your rest and let others do for you.
Soon you will be feeling fine.

What are the "baby blues"?

Sometime during the first few days or weeks, you may feel "down". It happens so often that it has been called the "baby blues". You may start crying for no reason at all. You may feel real grouchy! There are several reasons for this. Your body is making many changes getting back to the way it was before you were pregnant. If you kept your baby, you may not be getting enough rest. Most people _do_ get grouchy when they are tired. If you did not keep your baby, you may wonder if the baby is all right and how he's doing.

There's another reason that many new mothers get the blues. For nine months you had a lot of attention. Everyone did things for you. You may have felt very special. Now, your friends come to see the baby. They don't seem to even care how _you_ are feeling. You may not like having to stay home so much. You may wish you could be going out with your friends. You may even wonder if it's worth it all!

What can I do about the "blues"?

When you feel really "down", try doing something for yourself . . . relax in a warm bath . . . talk to a friend . . . read a good book . . . go for a walk or to a movie (if you have someone to take care of your baby). You will have these "down" times less and less often as you get used to being a mother.

What's it like being a mother?

You may not feel like a mother right after your baby is born. You have spent nine months waiting for this baby to come. Now that he's here, you may not feel like you thought a mother would feel. Maybe you thought of yourself as dressing this baby up and playing with him for a while. Then, when you were tired, you would just put him away! *Babies aren't dolls!* They need so much more love and care! Just when you think you can't stand any more, the baby starts to cry. You may not feel much love for the child at times like this! Every new mother goes through these feelings. It takes time for you to learn what your baby needs. As you learn, you will feel more and more like a mother. It's a good feeling when your baby stops crying because you pick him up and give him the love he needs! Each day, as you care for your baby, and learn to know him, you are getting to know what it means to be a mother.

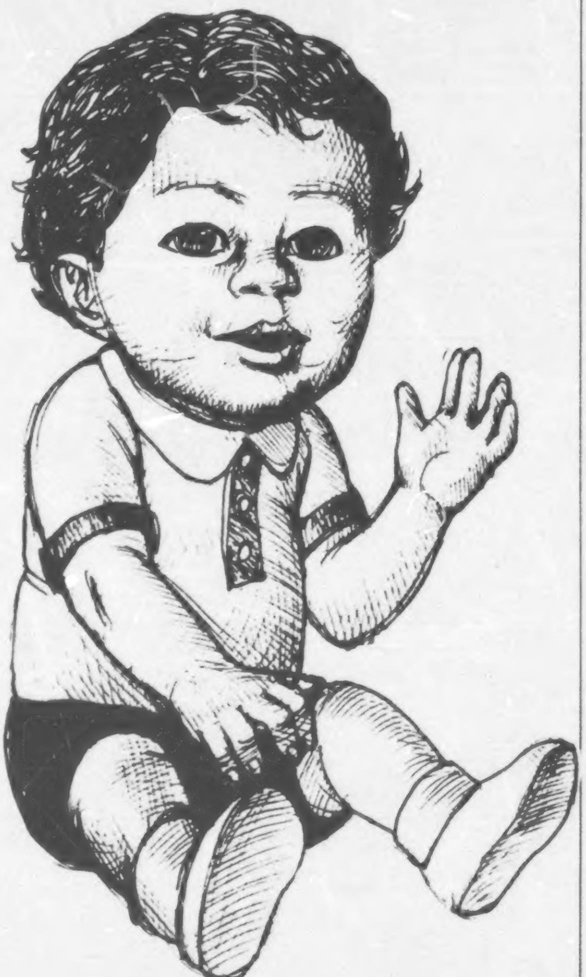
We'll talk about this more in the chapter called "Mama!" (Is That Me?).

HELLO, STRANGER!

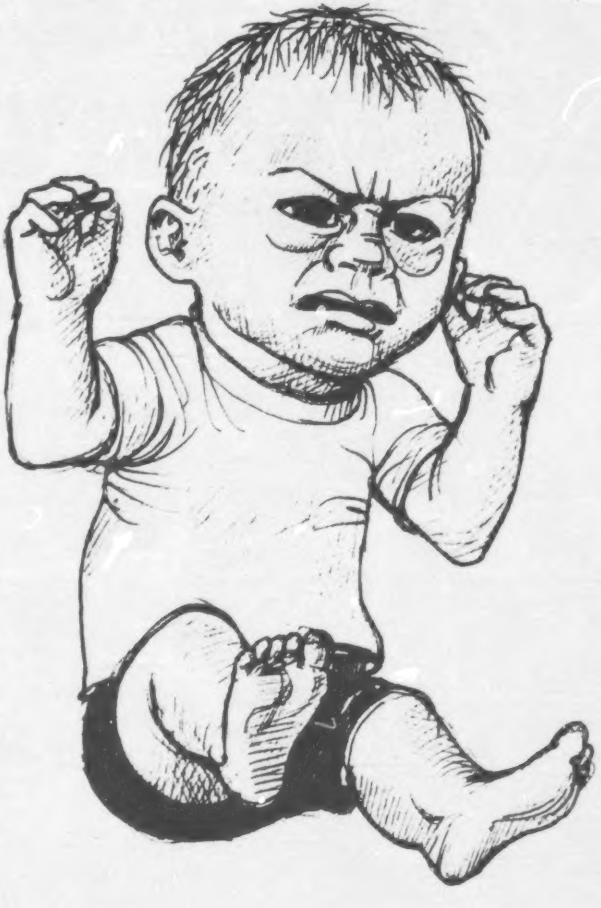
13

After nine months of pregnancy, the new baby finally arrives. For the first few days, and even weeks, you may not feel much like a mother. It will take time for you to know this little stranger.

Most new parents like to spend lots of time looking at their newborn. The baby can't tell you, but he likes this, too! In the hospital, you will want to unwrap the baby so that you can look him over and make sure he's all right. New parents also need to spend time touching their baby and holding him close. Both of these things will help you get to know him better. The more you do this, the closer you will feel to your baby.



The new baby is not always what the mother expected. Instead of looking like the Gerber baby, he looks like Uncle Joe! But as you get to know him, you will find plenty of things you like about him . . . his looks, his feel, the little sounds he makes, and other special things.



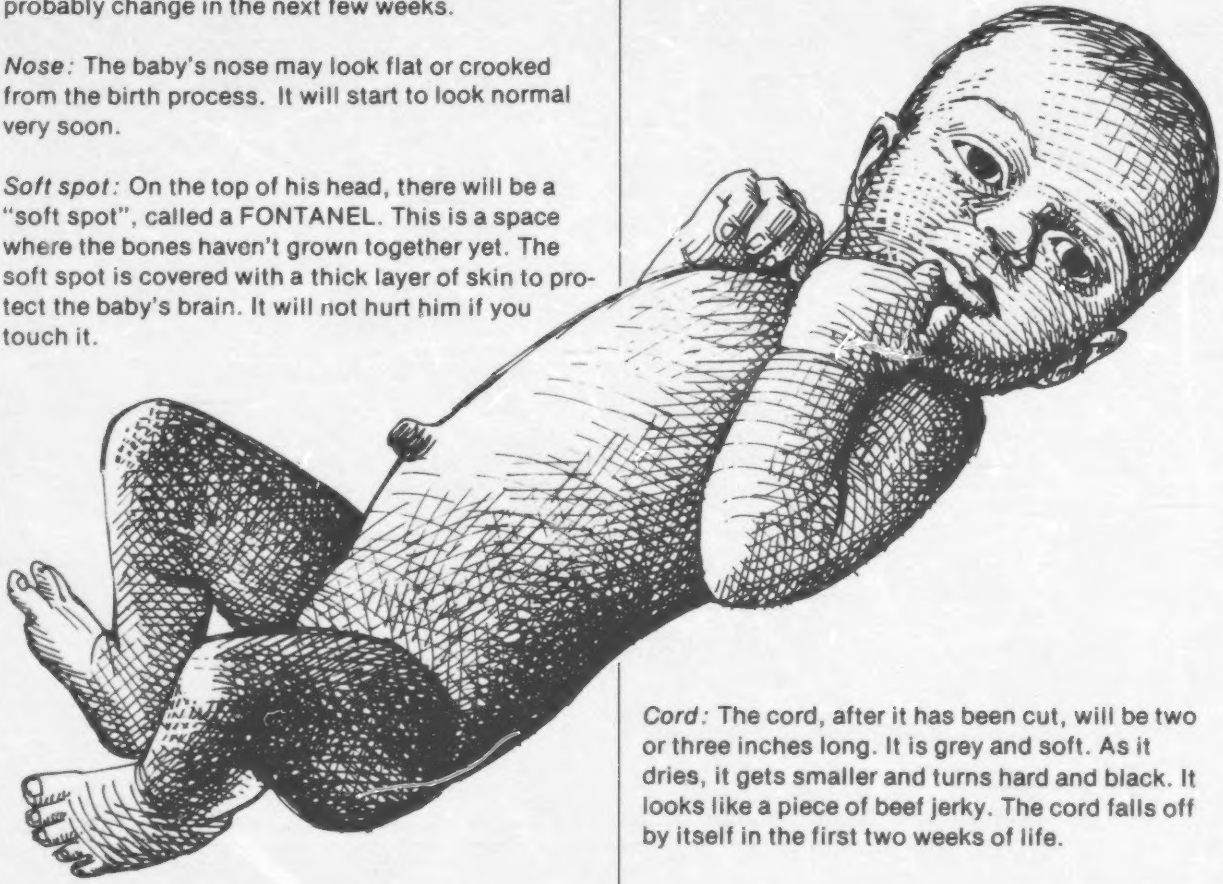
What does a newborn baby look like?

Head: You may notice that your baby's head looks too big for the rest of his body! His head may also have an odd shape right after he's born. Remember, his head was squeezed in the birth canal during labor. It will soon have a normal shape and any forcep marks will go away.

Eyes: For a few days, the newborn's eyes may look a little puffy or reddish. You may be surprised to see that they are a dark blue color. All babies are born with blue eyes. The color will probably change in the next few weeks.

Nose: The baby's nose may look flat or crooked from the birth process. It will start to look normal very soon.

Soft spot: On the top of his head, there will be a "soft spot", called a FONTANEL. This is a space where the bones haven't grown together yet. The soft spot is covered with a thick layer of skin to protect the baby's brain. It will not hurt him if you touch it.



Chin and neck: Where are they? Most newborns have small chins and very short necks. This makes it easier for them to suck during their first few weeks of life.

Body: The baby will have a rounded chest and little narrow hips. His legs look curved, and he often likes to sleep with them tucked under him. Remember, he was folded like that before he was born, so he's used to that position!

Skin: The baby's skin may seem dry and flaky. There may still be some of the white vernix between his fingers and under his chin. It is good for the skin, and there is no need to scrub it off.

Hair: Some newborns have lots of hair on their heads. Others don't have any. Many have extra hair on their faces, shoulders and backs. This soft body hair, called lanugo, protects the baby's tender skin. The baby will lose this hair in a few weeks.

Cord: The cord, after it has been cut, will be two or three inches long. It is grey and soft. As it dries, it gets smaller and turns hard and black. It looks like a piece of beef jerky. The cord falls off by itself in the first two weeks of life.

What can a newborn baby do?

Tiny babies look so small and helpless. But, it's amazing how many things the new baby can do as soon as he is born!

Sucking: Babies practice sucking and swallowing before birth. When the newborn arrives, he can do this pretty well! This is his only way of getting food. Sucking also makes him feel secure and happy. Between feedings he may enjoy a pacifier or even his thumb. This is good for him.

Hearing: The newborn can hear quite well. He can't understand your words, but he likes the sound of your gentle, loving voice. Spend time talking and singing to the baby. Loud, sudden noises or angry voices will scare him.

Seeing: The newborn does not focus his eyes well at first. Sometimes, they may look crossed. He can see light, bright colors, and shapes. He will enjoy bright colors above his bed and in his room. *Babies learn to love the sight of a human face quite early.*

Smelling: Most doctors believe that a baby knows his mother by her smell after a very short time! (This is also true of father or anyone else who holds him often.)

Touching: The baby's best developed sense is his sense of touch. He needs to be touched and held to develop normally. This is one of the best ways to let the baby know he is loved.

Crying: Babies cry for lots of reasons. They cry to tell you things, like "I'm wet," or "I'm hungry." They cry when they are uncomfortable or lonely. Sometimes they cry to exercise their bodies and develop their lungs. At first, the baby's cries will all sound alike to you. After a while, you will begin to learn the different kinds. For example, you will be able to tell a sleepy cry from a cry of pain. It is a good idea to pick up your baby when he cries. *It will not spoil him!* When you do pick him up, he learns that you care about him and that he is important. He learns to trust you.

What can I expect from my baby?

No two people are exactly alike! *That means no two babies are alike, either.* Your baby is one of a kind. From the moment of birth, you can see differences in the way they look and act. In the newborn nursery, you will notice that some babies stay awake and cry a lot. Others enjoy lying quietly in their cribs. Still others seem to want to sleep all the time.

You will soon learn to understand your baby and to know what's best for him. If your baby seems to get upset easily, you can make him happier by giving him calm, gentle care. If he is the sleepy kind, you may need to tickle his feet to wake him up for his feedings. *Love and accept your baby for being the way he is!* Knowing you love him will make him feel good about himself.

During the first few weeks, the newborn will wake up every few hours to be fed and changed. You can expect to be awakened several times during the night. This is a hard time for new parents. It may seem like all he needs is feeding, changing, and bathing. These first few months are *very* important to his physical and emotional growth. He needs love and tender care. Here are several ways to give the baby tender, loving care:

. . . Feed him when he's hungry
. . . Change him when he's wet
. . . Give him clean clothes
. . . Talk and sing to him
. . . Hold him securely (and often)
. . . Pick him up when he cries
. . . Don't hit or spank him

What are the baby's emotional needs?

Can you imagine what it would be like to be lying flat in your bed, with a pain in your side, an empty stomach, and very wet pants? Now imagine that you cannot talk or move your body. You feel awful! You need help! So you begin to cry out! You cry and cry and cry until someone comes.

What a relief when someone does come and tells you it will be all right! It feels so good to have dry pants with no pin poking in your side! Ah, now you're picked up and told it's time to eat. As soon as that milk begins to flow, your tummy starts to feel better. You realize that everything is O.K. now.

A tiny baby goes through something like this many, many times. If someone answers his calls for help, he begins to learn that the world is a safe and secure place to be. He begins to learn to trust others to meet his needs. He will feel good about his life.

What if he's left to cry and no one comes? What if he doesn't get fed when he's hungry? Or held close when he's afraid? A baby whose needs are not met has trouble developing a sense of trust. He learns that the world is an uncomfortable, unhappy place to live. He begins to feel badly about himself and others.

To develop normally, a baby needs loving care. He needs to have at least one person he knows he can depend on. It is the parent's responsibility to make sure a child gets the tender, loving care he needs to grow.

What are the baby's physical needs?

Feeding: You have a choice to make about the way you feed your baby. Breastfeeding is the natural way and it has many advantages. (See breastfeeding booklet.) Many women find it easier and feel good about nursing their babies. However, it may not be right for you. Going to school or to work may make it hard for you to breastfeed. Some young women have uncomfortable feelings about nursing a baby in front of husbands or boyfriends. Don't feel guilty if you don't want to breastfeed. Your baby can be healthy and loved if you bottlefeed.

Whether you decide to breast or bottle feed, *hold your baby during feedings.* This is a good time for the two of you to enjoy being close. It is also a good time for you to sit down and relax! Learn all you can about the ways to feed babies before your baby is born. Then you can make the choice that you feel will be best for your baby and you!

Holding: Don't be afraid to hold your tiny baby. He needs to be held close and cuddled often! When you pick him up, be sure to support his head.

Bathing: The baby's skin needs to be kept fresh and clean. Until the cord falls off, give him a sponge bath using a soft cloth, warm water, and mild soap. Put alcohol around his belly button to help it dry and heal. Always keep the diaper below the cord. It may look ugly to you, but it will heal better if it is kept dry. After the cord has fallen off, you can give the baby a tub bath. Don't be afraid to wash the soft spot on his head. It's tough and can be washed like the rest of his body. *Always* test the water to make sure it is not too hot. *Never* leave the baby alone on a bath table or in a tub.

Clothing: Your baby will feel best in soft, cotton clothes. You don't need fancy, frilly things. If your house is warm, you can dress the baby lightly. You will need to wrap him if the house is chilly or if you take him out on cold days. Helpful hint: Ask yourself how many blankets and sweaters you would need!

It can cost a lot of money to buy new clothing and equipment for your baby. Babies usually outgrow these things long before they are worn out. To save money, look for good buys at stores that sell used items. Often, other mothers are willing to share or sell clothes, cribs, and toys after their own babies have outgrown them.

HEALTH CARE: Regular check-ups with a doctor or clinic help keep your baby healthy. This is also a good chance for you to ask questions you may have. The baby will be given IMMUNIZATIONS (shots) to keep him from getting certain diseases. Be sure to keep a record of these shots because they will be needed when he starts to school.

If you notice a big change in the way your baby eats, sleeps, or looks he may be sick. If you think your baby is sick, call the doctor or clinic.

IMMUNIZATIONS

It is important to keep a record of the baby's shots.

Diptheria Whooping Cough (pertussis) Tetanus	These shots are given together and are called "DPT". They are usually given when your baby is 2 months, 4 months, and 6 months old. He will need booster shots at 18 months and 5 years old.

Oral polio drops are usually given at the same time as the DPT shot.

Measles Rubella (German measles) Mumps	These are usually given together and are called "MMR". They are given when your baby is between 13 and 15 months old.

SAFETY

There are a few simple rules to follow to make sure your baby is safe.

. . . Never leave him alone in the house or car.

. . . Never prop a bottle in his mouth (he can choke).

. . . Keep all small or sharp things out of reach (pins, buttons, coins).

. . . Keep all medicines, pills, polishes, cleaners, and other poisons out of reach.

. . . Don't use plastic bags as mattress or pillow covers.

. . . Don't leave him on top of anything (he might fall).

. . . Strap the baby securely in his tote seat, car seat, or cradleboard.

. . . In the car, it is best to use an approved safety car seat.

. . . Before giving baby a bottle, make sure the milk isn't too hot by shaking a few drops on your wrist.

Regular check-ups help keep your baby healthy.

"MAMA" (IS THAT ME?) 14

"It was really neat when I first saw my baby, because I would think "Wow, that's who's been kicking me!" It was also weird because I almost felt a kind of emptiness inside when he was born. I did not expect to feel that way. I just expected to be happy because I wasn't so huge."

"Having a baby has changed my life. I'm not as free. Now when I want to go somewhere, I can't just pick up and go. I have to get my baby ready, too."

It is a strange feeling to realize that you are the parent of a child! You really became a parent the moment you became pregnant. For nine months, you and the child have been one. You took good care of your baby by taking care of yourself.

Once the baby is born, motherhood changes. Your child is outside your body. You are now two separate people. The baby is no longer just part of your dreams and thoughts. Now you can see him as he really is. He is one of a kind with his own personality and needs.

You want to be a good parent. You want to raise a happy, healthy child. You also want to be yourself and be satisfied with your own life. You *can* do both. In this chapter, we will talk about some of the ways you can be happy and enjoy being a parent.

TO BECOME A GOOD PARENT, IT HELPS TO:

. . . feel good about yourself

. . . believe you can become the kind of parent you want to be

. . . understand that a lot of what you know about parenting comes from the way your own parents raised you

. . . understand and accept your responsibilities as a parent

. . . be realistic about what you expect of yourself and your child

. . . learn ways to relax and deal with tensions

Feel good about yourself!

That's right! Liking yourself is one of the most important things you can do! You are special. There is not another person in this whole world exactly like you. You have life and that makes you important!

You are human. That means that sometimes you do things well, and sometimes you don't. We all make mistakes. Mistakes give you a chance to grow and learn. Think about the things you like about yourself and the things you do well. It really is a waste of time to put yourself down. Think about the good things — this will help you feel better about yourself.

What does this have to do with being a good parent? Everything. If you don't feel good about yourself, you will also find lots wrong with other people. You can't give what you don't have. The amount of love you have to give your child depends on how much you love and respect yourself.

Believe you can become the kind of parent you want to be.

There are many different ways to raise children. These vary from culture to culture and from family to family. Whatever your background, you can raise a happy, healthy child. There is not another baby just like yours or another parent just like you. Believe in yourself! You will find your own best way of doing things.

Learning to be a parent begins when you are a child and goes on your whole life. If this is your first baby, you will feel unsure of yourself at times. All new parents feel this way. As you take care of this baby, your confidence will grow. You will continue to learn new and better ways of doing things. Relax and enjoy learning to be a parent!

You learned about parenting from your own parents.

You already have some ideas about what it means to be a parent. These ideas came from the people who took care of you as a child. Like it or not, we first learn how to be parents from our own parents!

Think back on your life as a child. What did you like about the way you were treated? Are there things you want to do differently with your own child? For example, you may feel that your own parents did not give you enough attention. You can choose to pay attention to your child and listen carefully to what he says. It is up to you to decide what kind of parent you want to be.

Accept your responsibilities as a parent.

You already know that a child has both physical and emotional needs. Your baby needs food, clothing, and a warm, safe place to live. To grow normally, he also needs love, acceptance, and help to learn. He needs these things from *you*.

When you make the choice to raise a child, you must be willing to give him what he needs. Being a good parent means giving of yourself.

Be realistic about what you expect of yourself and your child.

Do the best you can and don't expect yourself to be a perfect parent. Most of the time you will feel warm and loving toward your child. But there will be days when nothing seems to go right. At times, you may feel upset and angry. All parents have these mixed feelings. Accept this and do the best you can.

You will enjoy watching your child grow and learn. The newborn baby does not know much about the world when he first arrives. He has to learn it all. Sometimes, parents forget this and expect their little ones to know a lot more than they do. *Don't expect too much too soon!*

It doesn't do any good to try to teach a child things ahead of time. He can't learn them if he is not ready. You can't teach him to walk before he learns to stand. You can't potty-train him until he's at least a year and a half old, when his body is ready. You will both be upset if you push him. He will grow at his own speed and in his own way. Praise your child for each new thing he learns. This is one of the best ways to help him grow up happily.

Learn to handle life's up and downs.

Ups and downs are a fact of life. It's how you handle them that counts. You will enjoy life more if you can learn to relax and cope with tension.

When you are tense, your body may feel tight, your hands may shake, or your stomach may feel upset. At these times, you will need to find a way to relax. Sit or lie down for a few minutes and take some slow, deep breaths. You can also do the relaxation exercises you learned for labor. Soft, quiet music may also help.

It may also be hard for you to handle your feelings of anger. For sure, you won't want to take them out on the baby! Try some of these ways to let your anger out in a safe way. Crying can be a good way to get rid of anger. It may sound silly, but pounding on a pillow can also be a big help. Hard physical exercise, such as walking fast, running, or playing baseball is also very helpful. Find something that works for you. But don't let your feelings build up inside you.

If you find you're having a hard time handling your feelings, or if you are taking it out on the baby, don't mess around! *Find someone to talk to!*

Mother's natural feelings

Have you watched a mother cat protect her kittens? She will fight an animal much larger than she is to protect her babies. This same instinct is in you. You want to cuddle your baby and keep him from being hurt. Follow your instinct. There may be times when someone wants to hit or hurt your child. Don't be afraid to protect your baby if this happens.

Other Helpful Hints for New Parents

1. *Take some time for yourself each day.* Often you can relax alone while the baby sleeps.
2. *Have fun when you're away from the baby.* It's normal to want to leave the baby once in a while. Make sure he's well cared for by someone you can trust.
3. *Ask for help when you need it!* Many new mothers feel scared and confused at times. If you are alone, call a friend or another parent.
4. *Keep eating well.* It takes a lot of energy to recover from childbirth and to take care of a small baby.
5. *Give the man in your life the attention he needs.* Even though you are busy with the baby, you still need time together.

Fathers, Mothers, and Others

Fathers

Fathers are important, too. Your baby's father may be confused about what he can do. He may want the chance to be a parent. A young father usually wants to hold and touch his new baby. Often, he is scared and shy. He may feel jealous because you have the chance to do this and he doesn't.

You can help him learn to be a parent by asking him to hold the baby. He can be a big help with feeding, dressing, or bathing the little one. When he does, be sure to tell him he's doing a good job! The more chance he has to be with the baby, the more like a father he will feel. Fatherly love, like all love, needs time to grow.

Mothers (Your own mother)

If you and your mother are close and get along well, she can be a big help to you. She can teach you a lot about taking care of your baby. If this is her first grandchild, she may have to get used to the idea of being a grandmother. This may be hard for her.

Before the baby is born, it's a good idea to find out what she expects. Do you both agree on who will take care of the baby? Have you shared ideas about how the child will be raised? This is especially important if you plan to live at home. Get things clear as soon as possible. This will make it easier for all of you later.

Others

Other people can help you care for the baby while you are at school or at work. *Choose this person carefully!* Look for someone who is (1) warm and loving,(2) enjoys children, and (3) you can depend on. Watch this person carefully to see how he or she holds and talks to the baby. Drop in unexpectedly to see how your baby is being taken care of.

Both men and women can do a good job of "mothering" a baby. Their age is not as important as how much love, time, and energy they have to give. When you choose a babysitter, remember that your child needs tender, loving care.

FAMILY PLANNING: IS IT FOR YOU? 15

fam-i-ly plan-ning (noun): the methods and practices by which parents may regulate the number and frequency of their children

OR

family planning: having children when you want them and not having them when you don't

You have just completed one pregnancy. It's time for you to start thinking about when, or if, you will be pregnant again.

All of these things are a part of family planning.

***** DURING HER LIFETIME, A WOMAN WILL HAVE ABOUT 380 CHANCES TO GET PREGNANT.

***** THE AVERAGE WOMAN IS ABLE TO HAVE BABIES FOR ABOUT 32 YEARS OF HER LIFE.

***** HOW MANY CHILDREN YOU WILL HAVE, AND WHEN YOU WILL HAVE THEM, CAN BE YOUR CHOICE.

***** WHAT YOU DECIDE ABOUT HAVING CHILDREN DEPENDS ON MANY THINGS: YOUR GOALS, YOUR SITUATION, YOUR CULTURE, YOUR BELIEFS, YOUR RELIGION, AND YOUR HEALTH.

REACHING YOUR GOALS IN LIFE

*** How much education do you want?
*** Do you have dreams of a career?
*** Do you plan to marry?
*** Do you want children?
*** How many children do you want?
*** When do you want children?
*** What kind of a life do you want?

***** *Take your own goals into consideration when deciding about planning your family!*

LOOKING AT YOUR LIFE SITUATION

*** How many children can you support?
*** Do you depend upon your parents for money or a place to live?
*** Are you ready to spend your time and energy on child care?
*** Is there someone who will help you with child care?
*** Are your mind and body ready to be pregnant again?
*** If you choose a birth control method, will you use it?

***** *What's going on in your life will help you make choices about family planning.*

CONSIDERING YOUR HEALTH

*** It takes between one and three years for your body to be ready for another pregnancy.
*** Mothers are healthier if their children are not born too close together.
*** Children are healthier if they are not born close together.
*** Emotional health of parents is better if they are able to give all the love and attention each child needs.
*** Emotional health of children is best when their parents give them the love and attention they need.
*** The relationship between partners is healthier when they have enough time to spend together.

***** *Choices about family planning will affect the physical and emotional health of both parents and children.*

EXPLORING CULTURAL ATTITUDES AND BELIEFS

*** Some people prefer small families, while others like large ones.

*** Some cultures say it's best to wait to have children while others say have them while you are young.

*** Some people are against using any drugs or putting anything artificial in their bodies.

***** *Your cultural background will have an effect on the choices you make for your own life.*

FOLLOWING YOUR RELIGIOUS BELIEFS

*** Some religions say using birth control is a person's own choice.

*** Others say that people should use only natural family planning methods.

*** Still others believe that women should not limit the number of children they have.

***** *Your own religious beliefs can help you decide what is right for you.*

SHOULD YOU USE FAMILY PLANNING? THAT CHOICE IS YOURS!

To make a baby, it takes

one egg from a woman's body

and

one sperm from a man's body.

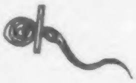
The way they get together is through sexual intercourse.

Only two things can keep them apart . . .

not having sex at all

or

a method of birth control that works.

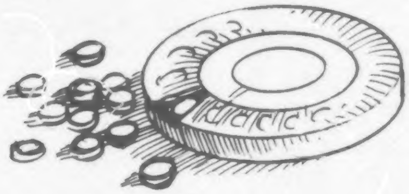


There is no perfectly safe time when you can have sex without getting pregnant!

THESE METHODS OF BIRTH CONTROL WORK BEST

The birth control pills, the I.U.D., and the diaphragm are the most effective methods of birth control. You can only get them from a doctor or a family planning clinic.

"THE PILL"



How it works:

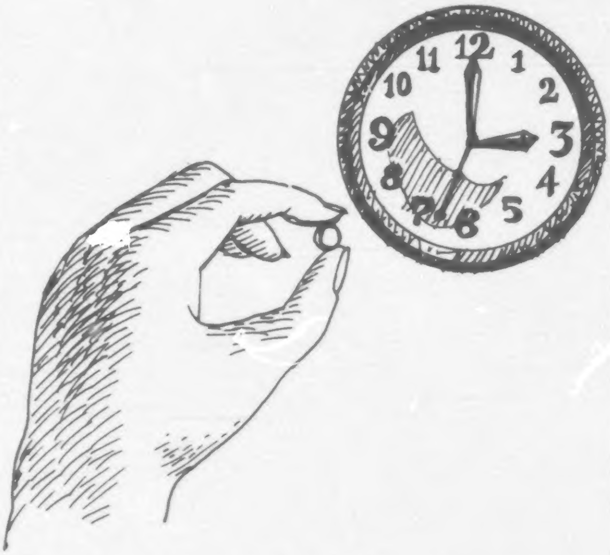
The pill is as close to 100 per cent effective as you can get. If you take it right, it stops your body from releasing the egg. When you take the pill, you are safe every day of the month. When there is no egg, there can be no pregnancy!

Everyone's body is a little different, so the doctor will need to decide which kind of pill is best for you. NEVER TAKE ANYONE ELSE'S PILLS!

How to use it:

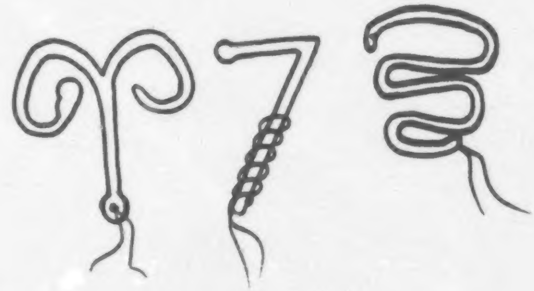
1. See your doctor or family planning clinic for a check-up and a prescription.
2. Follow the directions on the package.
3. Take your pills at about the same time every day.
4. *Be careful not to miss a pill.* If you do, DO NOT STOP TAKING THEM! Keep on taking the pills *and* use another method of birth control (such as foam and condoms) until all the pills in the package are gone.

Advantages	**Disadvantages**
Pills:	Pills:
-work very, very well -are easy to use -don't bother your lovemaking -help you have regular periods	-should not be used by some women -can cause side effects in a few women (nausea, swelling) -cannot be bought without a doctor's prescription



For the best results, your pill should be taken at about the same time each day.

"THE I.U.D."



The I.U.D. (intra-uterine device) is another method of birth control that works very well. Because of the many shapes of I.U.D. s, they are also known as "coils", "loops", and "Copper 7 s".

How it works:

No one knows just how the I.U.D. works, but it does! The doctor puts it into the uterus and leaves it there. This takes only a few minutes. Once it is in place, you are protected.

How to use it:

1. See your doctor or family planning clinic for a check-up and to have the I.U.D. put in.
2. After each period, check the threads in your vagina to make sure it is still in place. Make sure the nurse shows you how to do this!
3. If you think the I.U.D. has come out, use another method (like foam and condoms) until you have seen the doctor.

Advantages

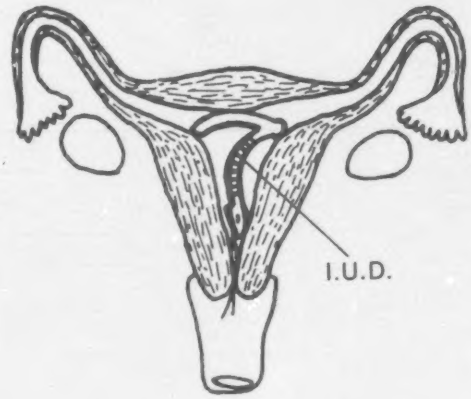
The I.U.D.:

- works very well
- is already in place when you need it
- does not bother your lovemaking
- is inside you, so no one can tell you have it
- can be easily taken out by a doctor

Disadvantages

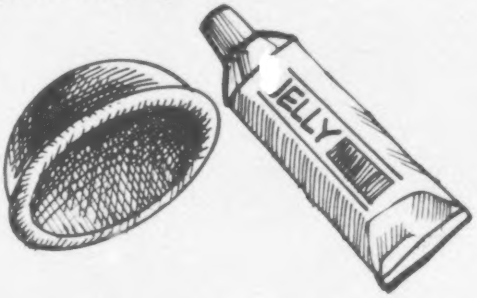
The I.U.D.:

- has unpleasant side effects for a few women (cramps, heavy periods, etc.)
- often can't be used by women who have never been pregnant



When the I.U.D. is in place, it is completely inside the uterus. Only the threads lay outside the cervix.

"THE DIAPHRAGM"



The diaphragm is a thin rubber cup which comes in different sizes. You will need to see a doctor to get fitted for the right size.

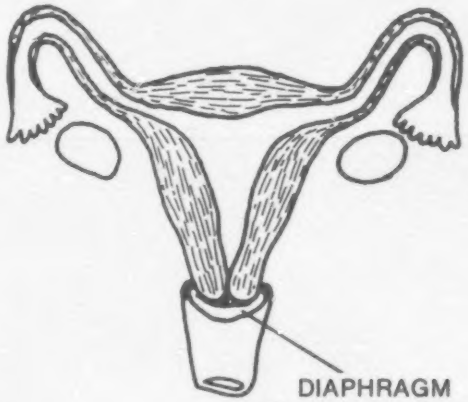
How it works:

The diaphragm is put into the vagina before you have sex. When in place, it covers the opening to the uterus and keeps sperm from going in. The diaphragm works best when it is used with a jelly or cream that kills sperm. The diaphragm does not hurt. If it is in the right place, neither you nor your partner will feel it.

How to use it:

1. See your doctor or family planning clinic to be fitted.
2. *Always* use the diaphragm with sperm killing cream or jelly, not Vaseline. (The doctor will tell you which one to use.)
3. Put the diaphragm in *before* you have sex. It should be put in not more than one hour ahead of time because the cream or jelly won't kill the sperm after that amount of time.
4. Leave the diaphragm in for at least eight hours *after* you have sex. Do not douche during this time. It washes away some of your protection.
5. You will need to put in more jelly or cream before you have sex again.
6. After you remove the diaphragm, it should be washed with a mild soap and water, rinsed, dried, and dusted with cornstarch.
7. Keep the diaphragm in its case when you are not using it. This will keep it clean and protected.

Advantages	**Disadvantages**
The Diaphragm:	The Diaphragm:
-does not have any side effects -can be put in before you make love -cannot be felt by either partner	-may not work quite as well as the pill or the I.U.D. -must be used every time you have sex

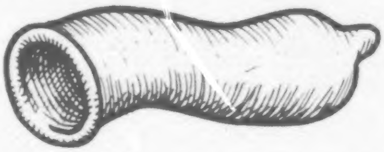


The diaphragm covers the opening to the uterus and keeps sperm from going in.

THESE METHODS ARE EASY TO GET AND, WHEN USED TOGETHER, GIVE GOOD PROTECTION.

Foam and condoms (rubbers) can be bought in a drug store. They are not expensive and you do not need a doctor's prescription. Foam and condoms work best when used together.

CONDOM ("Rubber", "skin", "safe", "sheath")



Condoms are the only method that can be used by the man. They are made of very thin rubber.

How it works:

The condom covers the penis. It works by catching the sperm and keeping them from getting to the egg.

How to use it:

1. Before intercourse, the man slowly unrolls the condom onto his hard penis. The whole penis will be covered. (This does not hurt.)
2. Leave about one-half inch at the tip to allow room for the sperm.
3. After intercourse, slowly draw the penis out of the vagina. Hold the top edge of the condom so that it does not slip off or spill.
4. *Important points:*
   -Use a condom only once, then throw it away.
   -Don't ever use Vaseline with the condom. It can make holes in the rubber.
   -Store condoms in a cool place. Heat can destroy the rubber.

Advantages

Condoms:

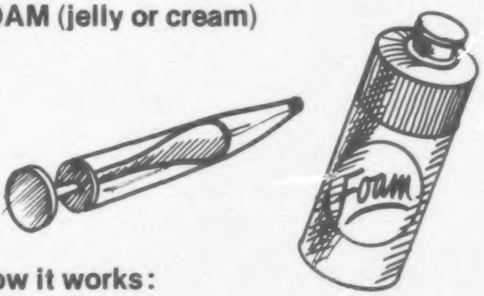
-can be used by a man
-are easy to get at the drugstore
-help protect you from V.D.
-work very well if used along with foam

Disadvantages

Condoms:

-must be used every time you have sex
-do not work as well as methods you get from a doctor

FOAM (jelly or cream)



How it works:

Vaginal foams, jellies and creams are put into the woman's vagina. These make a "wall" to block the sperm from entering the uterus. They also kill the sperm.

How to use it:

1. Always read the directions on the can.
2. Shake can well. Push the applicator against the nozzle of the can and it will fill with foam.
3. Put the applicator into the vagina as far as it will go (like you would use a tampon). Then push the plunger. This squeezes the foam into the vagina. Do this before you have sex.
4. Foam lasts about one hour. If you do not have sex within an hour, you will need to put more foam in again.
5. After putting in foam, do not get up and walk around because it will come out.
6. You will need to use more foam each time you have sex.
7. *Do not wash out the inside of your vagina (douche) for at least 8 hours after using foam.* This will wash away your protection.

Advantages

Foams, Creams, Jellies:

-are easy to get at a drugstore
-can be used as needed
-can be carried in your purse

Disadvantages

Foams, Creams, Jellies:

-do not work quite as well as pills or I.U.D.s
-must be used every time you have sex
-are thought to be messy by some people

NATURAL FAMILY PLANNING METHODS

Some people are against taking drugs or putting anything artificial in their bodies. They may think that natural methods are O.K. There are four kinds of natural family planning. These are based on the idea that the woman should not have sex around the time that she releases an egg.

A woman who wants to learn these methods needs to get help from a family planning counselor or a doctor. She can learn the signs in her body which tell her when she is ready to ovulate.

WHEN CHOOSING THE METHOD THAT'S RIGHT FOR YOU . . .

Seriously ask yourself the following questions:

1. How badly do I want to keep from getting pregnant?
2. Am I willing to do what it takes for my method to work?
3. Will I have confidence that my method will work?
4. Will I feel good about using it?
5. Will I have my method with me when I need it?
6. Will I have the time and privacy I need to use it?
7. How will it affect my relationship with my partner?

BIRTH CONTROL ONLY WORKS IF YOU USE IT! BE SURE TO CHOOSE A METHOD YOU'LL USE!

IF YOU THINK THESE WILL KEEP YOU FROM GETTING PREGNANT, FORGET IT!!!

. . . Douching with Coke or 7-Up
. . . Douching with anything
. . . Using Saran Wrap as a rubber
. . . Sitting or standing up during sex
. . . Breastfeeding
. . . Taking a shower after sex
. . . Feminine hygiene products (sprays, tablets, powders, douches, etc.)
. . . Withdrawal (pulling out before he comes)
. . . Having sex during your period

These things do not prevent pregnancy.

FOR THE FATHER OF THE BABY 16

Often, one of the hardest things a young woman has to do is to tell her boyfriend that she is pregnant. She wonders how the young man will feel about the pregnancy. Will he stick with her? Will he leave her to face it alone? You may wonder how other men feel when they are faced with the idea of being a father.

"*When Debi told me she was pregnant, I couldn't believe it. I knew there were reasons to get rid of it . . . but the thought of killing my child . . . knowing she would go through all that pain to have my child. I do love her! But I still need and want my freedom. Why can't I have both?*"

"*When she first told me she was pregnant, I just didn't believe her. Then I got to thinking, 'Well, how did I know it was my baby? For all I know she has been going out with other guys'. I just don't feel I should get all the blame. I don't want my life ruined. I'm not ready to get married.*"

"*We knew she was pregnant. I was happy and proud I was going to be a daddy. I was scared, too. I knew I'd have to get a job. Everyone says I'm crazy for getting married. I want the baby. It is mine and hers. We both really want it. It is going to be hard. My parents and her parents will help us. I think we can make it.*"

"*Since we got married, our old friends don't come around much. I miss going out with the guys and blowing off. I can't now with work and a wife and kid. I guess our real true friends are the ones who have gone through the same things we have.*"

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Teenage mothers seem to get a lot of attention. What about you, the young father? Do you feel like you're getting the attention you need? It's not easy to be a father. These words are for you.

Young fathers have many of the same problems as teen mothers. You may be confused about what will happen to your life. You may feel like everyone is blaming *you* for this situation. You may want to play a part in the lives of your child and its mother, but you may not know what to do. How can you share the responsibility? What about your education? What are others expecting of you? What about *your* future? You are an important person. Your thoughts and feelings count!

Some of the information in this book can be helpful to you. Look at the chapter called, "Making Decisions for You and the Baby." Ask yourself the questions about becoming a parent and getting married. What do you really want? How do you feel about becoming a father now? What effect will that have on your life?

Marriage may or may not be the answer. If you decide that marriage is not the answer, you can still give the girl the love and support she needs. She may be moody and hard to understand right now. One of the best ways you can help is to learn as much as you can about pregnancy and labor and delivery. Many young fathers want to be there when the child is born. Taking childbirth classes with the mother can help both of you get ready for this event. Your help during labor can make things easier for your wife or girlfriend. Being there will help you feel closer to your baby, too! Your role as a father begins with the support you give to the mother during pregnancy.

People used to feel that taking care of children was a mother's job. Fathers were the ones who brought home the money. Today, this is changing. Many young fathers are choosing to help raise their children. Look at the chapters called, " 'Mama!' (Is That Me?)" and "Hello, Stranger." Change the idea of mother to father and see how it all fits you!

In other chapters, we give you information that will help you make other important decisions. The chapters that talk about reproduction, sexual feelings, and family planning can help you better understand and deal responsibly with your own sexual feelings.

Many of your decisions may depend on money. Can you afford to support a family? If you are in school now, quitting may cut you off from a good future. To plan for your future, it's important that you finish school or go on with your training. If you are able to talk this over with your parents and her parents peacefully, that can be a big help, too.

It will help to talk all of these things over with someone you trust. Take time to make these big decisions. Then you'll have a better chance of making decisions you'll feel good about ten years from now.

A FINAL THOUGHT . . .

Pregnancy has been a part of your life.
You've grown up a lot through your trouble and strife.

You have shared your life with a child, for a while.
You have learned how to parent, in your very own style.

You've found that it takes lots of love and concern
To help a child grow and continue to learn.

Some of you chose to part ways with your child;
Others to parent for a very long while.

Whatever you do, be content with your choice.
In decisions you make, you do have a voice!

You have your own fears, your dreams and your hopes.
You've learned some new tools to help you to cope.

You grow, and you learn; you become more and more
A woman who handles all life has in store.

The love you accept and the love that you show
Has made you a beautiful person to know.

We know that your life will have struggles ahead.
We hope we have helped by what we have said!

We wish you well in your life and your health.
Remember the key . . . "BELIEVE IN YOURSELF!"

GLOSSARY

Abdomen - Sometimes called the belly; the part of the body between the chest and the hips. The stomach, intestines, ovaries and uterus are in the female abdomen.

Afterbirth - The placenta; the flat, round organ attached to the wall of the uterus during pregnancy. This organ makes it possible for the growing baby to get food and oxygen from its mother and get rid of waste products.

Afterpains - The contractions of the uterus following the birth of the baby.

Analgesia - A drug that relieves pain and/or tension.

Anemia - Known also as "low blood" or "iron deficiency anemia"; when there are not enough oxygen-carrying red blood cells.

Anesthesia - A drug that causes loss of feeling or sensation.

Bag of water - The membranes that hold the fluid that surrounds the unborn baby in the uterus.

Birth defects - Damage to baby before or during birth.

Bladder - The organ which holds urine (pee).

Bowel movements - Solid waste products after food has been digested, pushed out of the body through the rectum (bottom); known as "number two", "poop", "ca-ca".

Cesarean section - Removing the baby through a cut in the abdomen when delivery through the birth canal is not possible.

Cervix - Called "mouth of the womb"; the narrow end of the uterus that opens into the vagina.

Circumcision - Removal of the loose fold of skin that covers the end of the penis.

Colostrum - Yellow fluid in the breasts during pregnancy and the first two or three days after the baby's birth.

Contraction - Tightening of the muscles in the uterus during labor and delivery.

Dilation - Opening of the cervix during labor to let the baby come out.

Effacement - Thinning of the cervix during labor.

Ejaculation - Sperm coming out of the penis.

Embryo - Unborn baby during the first three months after fertilization.

Enema - A small amount of fluid put into the rectum (bottom), causing a bowel movement.

Engagement - Also called "lightening" or "dropping"; the moving of the baby down into the pelvis during the last month of pregnancy.

Episiotomy - Surgical cut into the skin of the perineum to make the opening bigger for the birth of the baby.

Erection - Hardening of the penis, sometimes called "hard-on".

Fallopian tube - "Oviduct"; narrow tube through which the egg passes from the ovary to the uterus.

Fertilization - Joining of egg and sperm in the Fallopian tube.

Fetus - Completely formed baby from third month of pregnancy until birth.

Fontanel - Soft spot on the baby's head, which allows the head to mold during birth.

Forceps - Curved metal tongs, used to help deliver the baby.

Gonorrhea - Disease of the reproductive organs, spread by sexual intercourse; type of venereal disease called "clap".

Hormone - A chemical made by some organs and carried by the blood, causing parts of the body to act in certain ways. (Example: female hormone — estrogen — produced in the ovaries causes breasts to develop.)

Implantation - The fertilized egg burying itself in the lining of the uterus.

Indigestion - Uncomfortable burning feeling in chest and throat when food is not digested well; also called "heartburn".

Intercourse - Sex act, when penis is in the vagina; also called "making it", "making love", "having sex".

Lactation - Process by which the breasts make milk for the baby.

Lanugo - Soft, downy hair growing on the body of the unborn baby.

Ligament - Strong piece of tissue that holds bones together or organs in place.

Membrane - A thin layer of tissue covering or connecting organs in the body. (Example: bag of water is a membrane.)

Menopause - "Change of life", when a woman's menstrual periods end and her ovaries stop releasing eggs, usually between ages 45 and 55.

Menstruation - Menstrual "period", monthly flow of blood and tissue out of the uterus through the vagina.

Midwife - Person trained to take care of the woman during pregnancy and childbirth.

Nocturnal emission - Natural release of sperm during sleep, called "wet dreams".

Ovary - Female organ producing hormones and egg cells.

Ovulation - Release of the mature egg cell from the ovary, about fourteen days before the beginning of the menstrual period.

Ovum - Female egg cell.

Pelvis - Frame of bones through which the baby is born.

Penis - Male sex organ for urination and intercourse.

Perineum - Area of skin between vagina and rectum, where the episiotomy is made.

Placenta - See Afterbirth.

Postpartum - "After delivery"; the period of time after the baby is born, usually six to eight weeks.

Prep - Shaving of hair from around the vagina before the baby is born.

Rh factor - A protein substance found in the blood of 85% of the population; if present, Rh positive; if not, Rh negative.

Show - Reddish-colored mucus plug from the cervix, usually a sign of labor.

Sperm - Male cell which can fertilize a female egg.

Syphilis - Disease of the blood spread by sexual contact; type of venereal disease.

Transition - Last two to three centimeters of dilation at the end of the first stage of labor.

Umbilical cord - Cord which connects the baby to the placenta; also called the "navel cord".

Urethra - Tube through which urine leaves the body, in both male and female.

Urine - Water carrying waste products out of the body; called "pee", "number 1".

Uterus - "Womb"; hollow, pear-shaped female organ in which the baby grows before birth.

Vagina - Passage in the female body leading from the uterus to the outside of the body, called the "birth canal".

Venereal disease - "V.D."; name for any disease which is spread by sexual contact.

Vernix - White, waxy coating which covers the baby while in the uterus to protect his body from the water.

Background of the Project

New Futures School has been serving adolescent parents of the Albuquerque community since January, 1970. Over 1,300 young women have benefited from its services in these seven years. Each year, the comprehensiveness of its services and the number of young mothers enrolled in the program have increased. The N.F.S. philosophy can best be summed up in the student comment, "At N.F.S., I found people who cared." Love and respect are the cornerstones of this program.

New Futures School was selected in 1976 as the outstanding program of its kind in the United States by the National Alliance Concerned With School-Age Parents. In 1978, DHEW Secretary Joseph Califano identified N.F.S. as one of four model programs for adolescent parents in the United States.

In recent years, N.F.S. has been increasingly called upon to provide leadership in the school-age parent field. Staff members have led workshops, given speeches, and served as resource persons for hundreds of groups concerned with teenage pregnancy.

The experience of the N.F.S. staff has prepared them for the next logical step, that of developing much-needed curriculum materials for pregnant adolescents. A grant was received from the New Mexico State Department of Education, Vocational Education Unit, to support this endeavor.

The co-authors of this book, Linda Barr and Catherine Monserrat, developed the curriculum for Family Life Education at N.F.S. and team-taught the class for five years. This book is a result of their experience in working with pregnant teenagers.

Mrs. Barr and Mrs. Monserrat have conducted workshops and given conference presentations on teenage pregnancy and parenting education at the state, regional and national levels. Most recently, they have taken leadership roles in conferences for the National Education Association, March of Dimes, P.T.A., National Alliance Concerned With School-Age Parents (NACSAP), International Childbirth Education Association and the Child Welfare League of America. Both women are members of NACSAP, Nurses Association of the American College of Obstetrics and Gynecology, March of Dimes board of directors, Planned Parenthood educational advisory committee, and honor societies in their respective fields.

Linda Barr was one of the original group of concerned volunteers who planned and initiated New Futures School. As the school's Health Director, she was responsible for health counseling in addition to teaching. Mrs. Barr is a registered nurse who received her masters degree in maternal and infant care nursing from the University of Florida. She taught baccalaureate student nurses for four years before assuming her role as Health Director at N.F.S.

Catherine Monserrat joined the N.F.S. staff early in 1971. During her years with the school, she taught classes in family living, child development, home economics, and nutrition. She also served as the Family Planning Specialist for the program. She has a B.S. in education. As an undergraduate, she specialized in family relationships and child development. She has a masters degree in Guidance and Counseling from the University of New Mexico.

The original text of *Teenage Pregnancy: A New Beginning* was field-tested in a variety of communities in New Mexico and Texas. Mrs. Barr and Mrs. Monserrat conducted training sessions for the teachers and other professionals who utilized the materials. Workshops were also held for persons interested in teenage parenting in the field-test communities. These materials proved to be effective in classroom settings and individual learning situations. As a result of the field-test experiences, the co-authors revised the original text into its current form. A Spanish-English version of this book is also available.

Project Coordinator and Editor, Caroline Gaston, has been Director of New Futures School since 1971. In addition to her responsibilities with the program, she has led many workshops and made speeches on adolescent pregnancy and related topics for local and state conferences, regional conferences of the Child Welfare League of America and DHEW, and national conferences for the Consortium on Early Childbearing and Childrearing, NACSAP, the National Conference on Social Welfare, and the National Association for the Education of Young Children. She was invited to participate in meetings with the DHEW Task Force on Adolescent Pregnancy and DHEW's Colloquium on Training Needs Related to Adolescent Pregnancy.

She was co-chairman of the New Mexico State Conference on Teenage Parents. In 1976, she received the National Achievement Award for Outstanding Contribution to School-Age Parent Program Development and Administration. She has served as a consultant on adolescent pregnancy to the Joseph P. Kennedy, Jr., Foundation. She has testified on adolescent pregnancy before the United States Senate.

Mrs. Gaston is a member and officer of the board of directors of the New Mexico Family Planning Council and a member of the DHEW Region VI Sub-task Force on Parenting Education.

Toni Berg, R.N., has been a member of the N.F.S. staff for two years. She is currently the Health Director. Prior to that time, she was the Education Coordinator for the University of New Mexico Maternal and Infant Care Project. She is the author of *Prenatal Guidebook*, a publication of the M & I Project.

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WORKING WITH CHILDBEARING ADOLESCENTS

A Guide For Use With

Teenage Pregnancy: A New Beginning

Linda Barr [illegible] Catherine Monserrat

WORKING WITH CHILDBEARING ADOLESCENTS

A Guide for Use
with

Teenage Pregnancy: A New Beginning

By
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"Learning is finding out
what you already know.

Doing is demonstrating that
you know it.

Teaching is reminding others
that they know just as well as you.

You are all learners,
doers, teachers."

Richard Bach
Illusions

Foreword

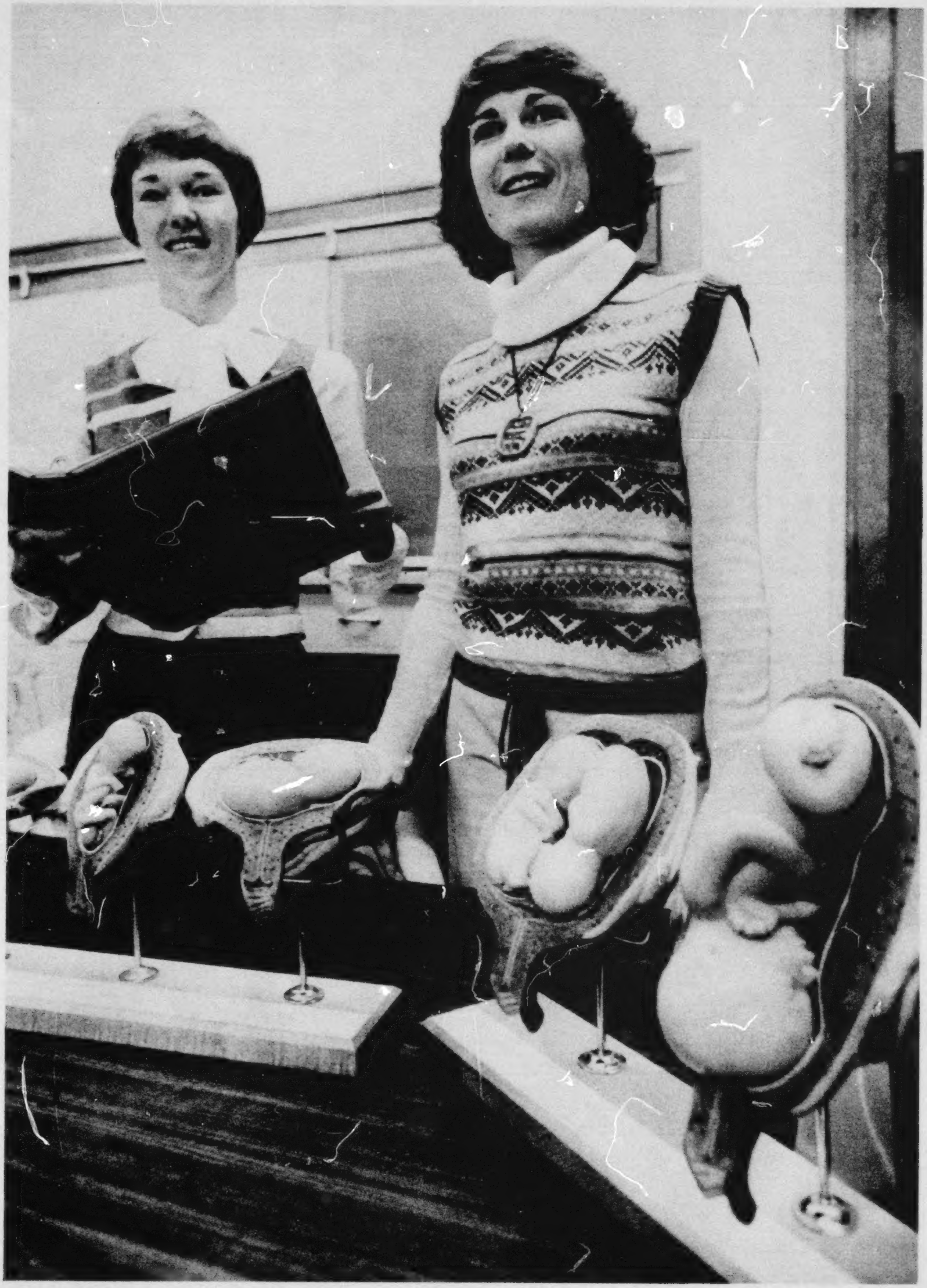
It has become axiomatic to those of us who deal with problems of adolescent pregnancy that adolescent pregnancy has implications which reach far beyond the health care of young people. Adolescent pregnancy, in fact, reflects many of the unfortunate phenomena in our society. Pregnant teens are a high-risk class of patients medically, a group of individuals for whom consumer education is critically important, and a group of individuals who are obstructed in obtaining the privileges of the society in which we live as regards to education and employment. They serve to alert us to the inadequacy of day care and health care facilities and to the fact that we have a distressing lack of information about human sexuality. All of these ills and many others are highlighted by observing teenage pregnancy and its sequelae.

In a previous book, *Teenage Pregnancy: A New Beginning*, the group from Albuquerque, whose New Futures School has served as a role model for similar schools, highlighted those potential problems which are preventable or correctable. The book educates both consumers and providers and supports the continued progress of the teen mother. Traditionally, the adolescent and the adult are deaf to each other as far as sexuality and its consequences are concerned. Different attitudes, different modes of conduct, different cultural and social foci are but a few of the reasons for this estrangement. As a consequence, *Teenage Pregnancy: A New Beginning* developed for the student, in ways which the student understands, approaches to overcoming the possible pathology associated with adolescent pregnancy. Similarly, its content explored in realistic language the real world, emphasizing individual responsibility and individual options.

During the development of the adolescent pregnancy support movement in the late 50's and early 60's which recently culminated in the Teen Pregnancy Initiative, one factor that became increasingly evident was the isolation and tunnel vision of the numerous groups working with adolescent pregnant patients and clients throughout the United States. Social workers were cut off from educators, educators were cut off from health care professionals; and, commonly, professional groups addressing the same problems in the same community were unaware of each other's existence. It is clear that each of the professional specialties has information, techniques, and talents which expand the impact applications of the other specialties; that such specialties are symbiotic.

The authors of this text, Linda Barr and Catherine Monserrat, are eminently qualified to bring together the various nuances in approaching the teenager who is pregnant or simply sexually active. Adolescent pregnant women are not a homogeneous group. Each individual has needs which are unique to her and which commonly require individual attention. This book, *Working With Childbearing Adolescents*, is not intended to be applicable directly to each individual teenager. It is designed to provide general strategy and general methodology for dealing with the pregnant adolescent. Only by awareness, sensitivity, and the type of effort this book represents, can the negative implications of adolescent pregnancy be modified. This book's approach can help our youth to reach their true potential.

Phillip J. Goldstein, M.D.
Obstetrician & Gynecologist-in-Chief
Sinai Hospital of Baltimore
February, 1980



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A Word From The Authors

A decade ago the adolescent pregnancy field was still in its infancy. At that time we began our careers with pregnant teenagers as volunteers working in the basement of the Albuquerque Y.W.C.A. As we were struggling for mere survival then, we would have laughed had anyone suggested that one day we would be writing books on the subject Those early years of struggle and the many beautiful relationships we experienced with the young women in our program have contributed both to our professional and to our personal growth.

The evolution of a new program is an exciting and challenging process. Our program began in January, 1970, as a result of the dedicated efforts of a few members of the local Y.W.C.A. At that time young women who became pregnant were expelled from the public school system. The concerned women from the Y.W.C.A. believed that a pregnant teen should have the opportunity to continue with her education and to receive medical care. This group provided the classroom facilities and became the coordinating agency for services to pregnant adolescents. Representatives from community agencies formed an advisory board and gave commitments of cooperation. The Albuquerque Public School system agreed to accredit classes that were offered. The Maternity and Infant Care Project provided prenatal care services in one of their satellite clinics. Major financial problems remained, however.

Three teachers and a nurse volunteered to teach on a part-time basis. On the first day of school, two young women enrolled in the program. By the end of the first semester we had served twenty-one pregnant adolescents.

New Futures School has experienced steady growth both in number of students served and in the breadth of services offered. N.F.S. now has a staff of forty dedicated teachers, nurses, counselors, day-care givers, and support persons. The program currently serves over four hundred young women, their children, and their families each year. Our services include academic, vocational, and parenting education; counseling and social services; health care; day care; and other special programs for young fathers and family members.

As staff members during the early formative years, we wore many hats, taking on new responsibilities as the enrollment grew and the demands increased. Linda's background in maternal and infant care nursing proved invaluable in her duties as Health Director for the program. Catherine was trained as a family life educator and later as a counselor. In addition to her teaching responsibilities, she developed programs in family planning, day care, and nutrition. Together we taught the Family Living classes for six years.

We searched continuously for suitable materials, relying heavily on the use of free and inexpensive pamphlets. Often these materials were not appropriate for our students' ages, marital status, reading and interest levels, and cultural backgrounds. When we occasionally discovered literature or films that were appropriate, we were exhilarated. Quite honestly, we were waiting for someone else to develop the curriculum we desperately needed to teach our teenage mothers about pregnancy, childbirth, and parenting.

After six years we realized that we had accumulated enough experience, expertise, and materials to develop our own curriculum. Though neither of us was experienced in writing, we decided to undertake the project. In 1977 with a grant from the New Mexico State Department of Vocational Education and with encouragement from colleagues, we tackled the project of writing *Teenage Pregnancy: A New Beginning.* Initially we thought the student text would be used at New Futures and perhaps in other communities in our part of the country. We never dreamed that the book would be used in all fifty states and even in several foreign countries! It is truly gratifying to know that those of you working in the field have found it useful.

In the past three years we have devoted much of our time to community and professional education, presenting workshops and providing technical assistance to persons interested in the field of adolescent pregnancy and parenting. These experiences have made us aware of the need for a text providing comprehensive information and technical assistance for adults who work with childbearing adolescents. New

Futures School receives numerous requests for information, ranging from basic questions regarding the scope of teenage pregnancy to the more philosophical issues of assisting young women in decision making and in the improvement of their self-concepts. In addition, we have discovered an almost universal need for an increased awareness of the nature of adolescence. The understanding of adolescence is essential in bridging the gap between helping persons and the young people with whom they work.

This book is a sharing of our own experiences, insights, and ideas for working meaningfully with these young people. It is our hope that this sharing will assist you in increasing your own level of sensitivity as well as in offering practical methods of approaching your work. We also hope that this book will be helpful to professionals in a variety of fields; and we encourage you to develop a unified, multidisciplinary effort in working with childbearing adolescents.

A book is only a book, however. The young women with whom you work will be your most valuable teachers. We deeply treasure the relationships that we developed with our students over the years. Many of these young people have continued to keep in touch with us. We are proud and gratified to see that the majority of them have become good parents and effective individuals. May you also experience personal satisfaction as you support young women in their growth toward their highest potentials as individuals and as parents. These young people and their children are the substance and future of our nation.

This book would never have become a reality without the support and assistance of our colleagues. We express our warmest appreciation to Caroline Gaston, our program director and editor, whose caring and support have made this book possible. We also wish to express deep appreciation to the following people: Dr. Richard Murray, Director, Sandra Gale, Assistant Director, and other staff of the New Mexico Improved Pregnancy Outcome Project for their critical comments; Dr. Phillip J. Goldstein for his forewording remarks; Sally Wood for her technical and editorial assistance; Jeanne Lindsay for her assistance with printed resources; Laurie Kalter for help with film reviews; Susie Bedingfield and Marinel Hartogensis, for their excellence and patience in editing and manuscript production; N.F.S. staff members Lee Protomastro, Toni Berg, Susan Jones, Nina DeBerry, and Anna Petty for the use of their ideas and comments; and Kay Carter for years of affection and all-purpose support. We especially want to thank our families for their continued love and support and for their continued reinforcement of our careers.

Linda Barr
Catherine Monserrat
February, 1980

Part One

ADOLESCENT PARENTS:
NEEDS AND SERVICES

Adolescent Parents: Needs and Services

by Caroline Gaston, Program Coordinator
New Futures School

In recent years adolescent pregnancy and adolescent parenthood have been receiving increased public attention. Articles on teenage pregnancy have appeared in popular women's magazines; national news media have carried features discussing the topic; and Congress has heard testimony regarding its extent, its antecedents, and suggested means for its prevention and for provision of services to ameliorate its negative effects. Why should the public be concerned about adolescent parenthood? If the concerns are legitimate, how can services be provided to assist the individuals who are affected?

Any discussion of adolescent pregnancy should begin by noting that the concerns surrounding this issue are directed primarily at young people seventeen years of age and younger and to those who have not completed their high school educations. It is our belief that there are a number of reasons that society should be concerned about adolescent pregnancy. We also believe that there have been demonstrations of the fact that services, properly provided, can have a positive impact on the lives of those affected by adolescent pregnancy. Such services have proven to be both meaningful in human terms and cost-effective.

Statistics on Adolescent Pregnancy

Approximately one million teenagers become pregnant each year. Girls fifteen years of age and younger make up an increasing percentage of this population. Approximately 60 percent of these pregnancies result in live births. Across the country almost one out of every five babies is born to a teenage mother. You can find out what this percentage is in your state and community by contacting your state health agency. Many people believe that a teenage mother will have "learned her lesson." Statistics do not support this view. Twenty percent of births to teenagers are second or third births. Studies have reported repeat pregnancy rates as high as 70 percent within two years.

Implications of Adolescent Pregnancy and Parenthood

Physical Implications

Although researchers do not always agree on specifics, adolescent pregnancy is generally considered to be medically high risk for both mother and baby. The young woman's physical growth and maturation is usually not complete until the end of the adolescent years. The added demands of pregnancy on an immature body may lead to serious health problems. It is generally believed that the nutritional status of the pregnant woman plays a significant role in the outcome of her pregnancy. Because many teenagers have poor diets, they enter pregnancy at a nutritional disadvantage. A recent survey of Oklahoma school youngsters showed that only 11.5 percent of girls in grades 10-12 had minimally adequate diets. It is also generally recognized that good prenatal medical care contributes to a good pregnancy outcome. Many teenagers do not recognize or acknowledge pregnancy during the crucial early months, thereby delaying prenatal care.

Maternal complications most often cited as being higher in the teenage population include toxemia, anemia, prolonged labor, and cephalo-pelvic disproportion (small pelvis in relation to the size of the baby's head). Statistics indicate a higher maternal death rate for teenage mothers than for women in their twenties. Health risks for the babies born to teenage mothers include prematurity, low birthweight, and increased neonatal and infant mortality. The incidence of complications for both mother and baby increases as the age of the mother decreases; the incidence of complications is also higher for second or third children born to adolescents.

Educational Implications

Adolescent parenthood is the largest cause of school drop outs with 80 percent of school-age mothers never finishing high school. A decade ago most pregnant students were expelled from school if they did not choose to drop out. Today the picture is changing. Federal regulation now requires that adolescent parents be allowed to remain in school. Practice, however, may vary widely among communities. Often a young woman does not feel comfortable about remaining in her school during pregnancy. Even if the young mother is able to remain in school during her pregnancy, she often drops out after her baby is born because of lack of appropriate child care, health problems of herself or of her child, a need to earn income, or personal problems.

Social Implications

Many adolescent parents face a number of personal problems that result from their untimely parenthood. The insecurity common to many adolescents is exacerbated by the negative feedback they get from friends and family because of the pregnancy. Adolescent parents are uncertain as to whether they are children or adults. Their behavior vacillates between the two; they sometimes want to be treated as one and sometimes as the other. The decisions they must make often seem overwhelming to them.

If a young couple marries primarily because of the pregnancy, there is an 80 percent chance of divorce within five years. The responsibilities of marriage and parenthood, coupled with their individual needs for personal growth, may be overwhelming for the young pair. The teenage mother who marries has a decreased likelihood of graduating from high school and an increased likelihood of closely spaced repeat pregnancies as compared to the single adolescent mother. On the other hand, breaking up with the father of the baby or being abandoned by him can be very traumatic for her. Whether married or remaining single, a teenage mother often finds herself socially isolated. She is neither a "typical adult" nor a "typical teen" and must find her way without feeling a part of either society.

The degree to which a young woman's family and her relationship to it are affected varies widely. Some families are able to accept the pregnancy and the child without much difficulty. Others may experience serious problems in family relationships. Some grandparents want nothing to do with further childrearing and resent any imposition on them for financial or child care assistance. Others may welcome the opportunity to help rear another child. Some families cannot think of their daughter attempting to raise a child as a single parent while others cannot accept the possibility of her releasing their grandchild for adoption. Whatever the specific reaction, however, most families are concerned for the well-being of their daughter and for the future of the child.

For some adolescent parents, pregnancy is not the largest problem they face. These young women may need help in coping with what they perceive to be their major problems before they can turn full attention to preparing for the responsibilities of pregnancy and parenthood.

Economic Implications

Many teenage mothers say that their biggest problems are financial. Many find that because they lack the necessary education and training, they cannot get a job that pays adequately. Adequate day care that they can afford is often not available. Therefore, many young mothers end up on welfare rolls. A study by Kristin Moore found evidence that half of the AFDC budget is expended on households in which the mother was a teenager at the birth of her first child. We have observed that some young mothers are reluctant to go to work because they are caught up in society's ambivalence as to whether a working mother can be a good mother. Because these mothers want so much to demonstrate that they are good parents, they may opt to play the traditional mothering role.

The young father may also be suffering damaging effects. He too may drop out of school, take a low-paying job, and experience the financial drain of parenthood.

Parenting Implications

The Guttmacher Institute reported in *11 Million Teenagers* that 90-95 percent of teenage mothers choose to keep their children rather than to release them for adoption. These young mothers face parenting responsibilities for which they are many times ill prepared.

We believe that young parents want to be good parents. Because of their lack of maturity, their lack of self-confidence, and the difficult situations in which the early pregnancy often places them, however, it may be difficult for them to achieve this goal. They often have unrealistic expectations of their children and of themselves. Education and counseling regarding parenting skills and attitudes are essential components of a comprehensive program for teenage parents.

Services for Adolescent Parents

Intervention strategies have been developed that have been demonstrated to be effective in meeting the needs of adolescent parents. Specialized services to adolescent parents began with a few demonstration projects in the latter

part of the 1960's. Their numbers gradually increased throughout the decade of the 70's.

We and many others believe that there are three key elements to any successful program for adolescent parents. Services must be (1) comprehensive, (2) coordinated, and (3) provided in an atmosphere of care, concern, and respect for the individual and her culture.

The provision of comprehensive services means that the services must address, at a minimum, all of the issues addressed above. Services that focus on one concern to the exclusion of others will be handicapped in effectiveness. Health services addressed to both mother and child should be provided. Nutrition and family planning should be integral parts of the health services. Young mothers should have an opportunity to progress toward a high school diploma or equivalent. In addition, they should receive education in particular areas of immediate concern to them such as perinatal health, parenting, and consumerism. Counseling and social services should be regularly available. Vocational and career education, counseling, and perhaps job placement should be provided. Day care services are usually necessary, both to ensure that the young mother can avail herself of the other services and as learning laboratories in child care. Comprehensive services should address the young mother, her child, her family, and the father of the baby to the greatest extent possible.

Services must be coordinated to ensure coverage of all areas, to avoid duplication of effort, and to eliminate conflicting messages to the adolescent. Such coordination must be real and on-going. It is not easy for a variety of reasons. It means establishing effective communication between professional fields in which languages and priorities are often different. It means that each entity must give up a little of its "turf" and must be prepared to share the credit for whatever results. It often means a pooling of funding resources with a variety of targets, priorities, reporting requirements, and funding cycles. Congressional legislation calls for coordination of effort, but government regulations often are not written to facilitate such an effort.

Services should be provided in a setting that is warm, comfortable, and accepting. Staffing patterns that reflect the socio-ethnic composition of a program's clientele help young mothers to feel comfortable and help to ensure that cultural traditions will be understood and respected. The service provider should have a genuine belief in the potential capability of the expectant mother. Both overt and covert signals tell teenagers how adults feel about them. Negative feelings by helping providers can damage a young mother's self-confidence and thereby her ability to utilize services and to have a successful pregnancy experience. Adults who work with pregnant teens must have a good understanding of the characteristics of adolescence and must have skill in communication with adolescents. "Telling them what to do" is very often ineffective whether it be done by health providers, teachers, or social workers.

Three general types of service models exist. The first is the "single agency" model wherein one agency provides under its administrative umbrella all the comprehensive services at its site. Our own program, New Futures School, is of this type. The second, the "side-by-side" model, brings together services provided by a number of agencies into a single service setting. The third, a "coordination" model, calls for a lead agency to assume the responsibility for ensuring that the expectant mother receives all necessary services by referring her to appropriate resources and by tracking her to ensure that she does indeed receive needed help. Some very effective programs for adolescent parents are school-based. Other equally effective programs are based in hospitals or in private community agencies.

We believe that it is important for services to adolescent parents to begin as early in pregnancy as possible. If programs concentrate only on crisis intervention, however, there may be no lasting effects in the lives of these young persons. Continued support through follow-up services is often essential to help break the cycle of repeat pregnancies, school drop-out rates, and poor socioeconomic outcomes. Services during the year in which their children are born are sufficient to set some young parents on a road toward responsible maturity. For others, making staff available on a need basis in subsequent years is sufficient. Still others need more intensive follow-up services. Some programs have developed models to meet the ongoing needs of specially identified young parents. These include the Infant Stimulation Program at Grand Rapids' Park School, intensified follow-up counseling for identified high-risk mothers at Tulsa's Margaret Hudson Program, day care for children up to three and one-half years of age at The Delaware Adolescent Program, and Johns Hopkins' postnatal program. New Futures School has recently added a Young Parents Center, a high school program with parenting education, day care, and vocational orientation and preparation as primary components. This program has been designed for high-risk young mothers with children up to three years of age.

Information on Program Development and Funding

The identification of funding sources for the development of comprehensive services for pregnant teens must begin within the community. Community meetings should be held to identify existing resources that can be focused on pregnant teens. Such resources may well include local education agencies, health providers (both public and private), social service agencies, voluntary agencies, individual volunteers, universities, and churches.

After this step has been accomplished and local commitments are made, it is then time to look for "outside" funding. A complete "laundry list" of funds that are being used in various communities for services to adolescent parents would be too lengthy to include here. The resources listed below can provide you with important information about how to develop and fund a program for adolescent parents.

The United States Department of Health, Education and Welfare (Department of Health and Human Services) has established an Office of Adolescent Pregnancy Programs. The purposes of this office are to coordinate the efforts of various agencies within the Department that provide services related to adolescent pregnancy, to provide technical assistance to those interested in serving adolescent parents, and to implement Public Law 95-262, the "Adolescent Pregnancy" legislation. You may contact this office by writing to

Dr. Lulu Mae Nix, Director
Office of Adolescent Pregnancy Programs
Room 725-H, Humphrey Building
200 Independence Avenue SW
Washington, D.C. 20201

The new Department of Education is also interested in adolescent pregnancy. Within this Department you should contact

W. Stanley Krueger, Director
Parent/Early Childhood and Special Programs Staff
Bureau of School Improvement
400 Maryland Avenue SW, Room 2083
Washington, D.C. 20202

This office can provide technical assistance to organizations or individuals wishing to plan new programs or to improve existing comprehensive services for adolescent parents.

The United States Department of Labor has become increasingly concerned about the impact of adolescent pregnancy upon the employability of youth. The Women's Bureau of this Department is providing some funding to adolescent parent programs with employment components. The Office of Youth Programs may be contacted regarding information and possible funding sources. The contact within the Department of Labor is

U.S. Department of Labor/E.T.A./O.Y.P.
601 D Street NW
Washington, D.C. 20213

There is a new national organization serving the adolescent pregnancy field. This organization, the National Organization on Adolescent Pregnancy and Parenting, can provide you with important information. Your membership in NOAPP can provide you with a mechanism through which you may express your concerns regarding adolescent pregnancy at a national level and through which you may contact others working in this field. Some states have statewide alliances or networks addressing adolescent pregnancy. NOAPP can help you get in touch with them.

You may contact NOAPP by writing to

James Hill, Secretary-Treasurer
c/o DAPI
1401 N. Market Street
Wilmington, Delaware 19801

The March of Dimes Birth Defects Foundation (formerly the National Foundation/March of Dimes) is very active in the adolescent pregnancy field. You may contact your local chapter or

Education Department
March of Dimes Birth Defects Foundation
Box 2000
White Plains, New York 10602

The Joseph P. Kennedy, Jr., Foundation has also become very involved with adolescent pregnancy. The Foundation is playing a major leadership role in the field and has provided technical assistance to some programs. You may contact them by writing to

Eunice Kennedy Shriver
The Joseph P. Kennedy, Jr., Foundation
1701 K Street NW, Suite 205
Washington, D.C. 20006

Reference

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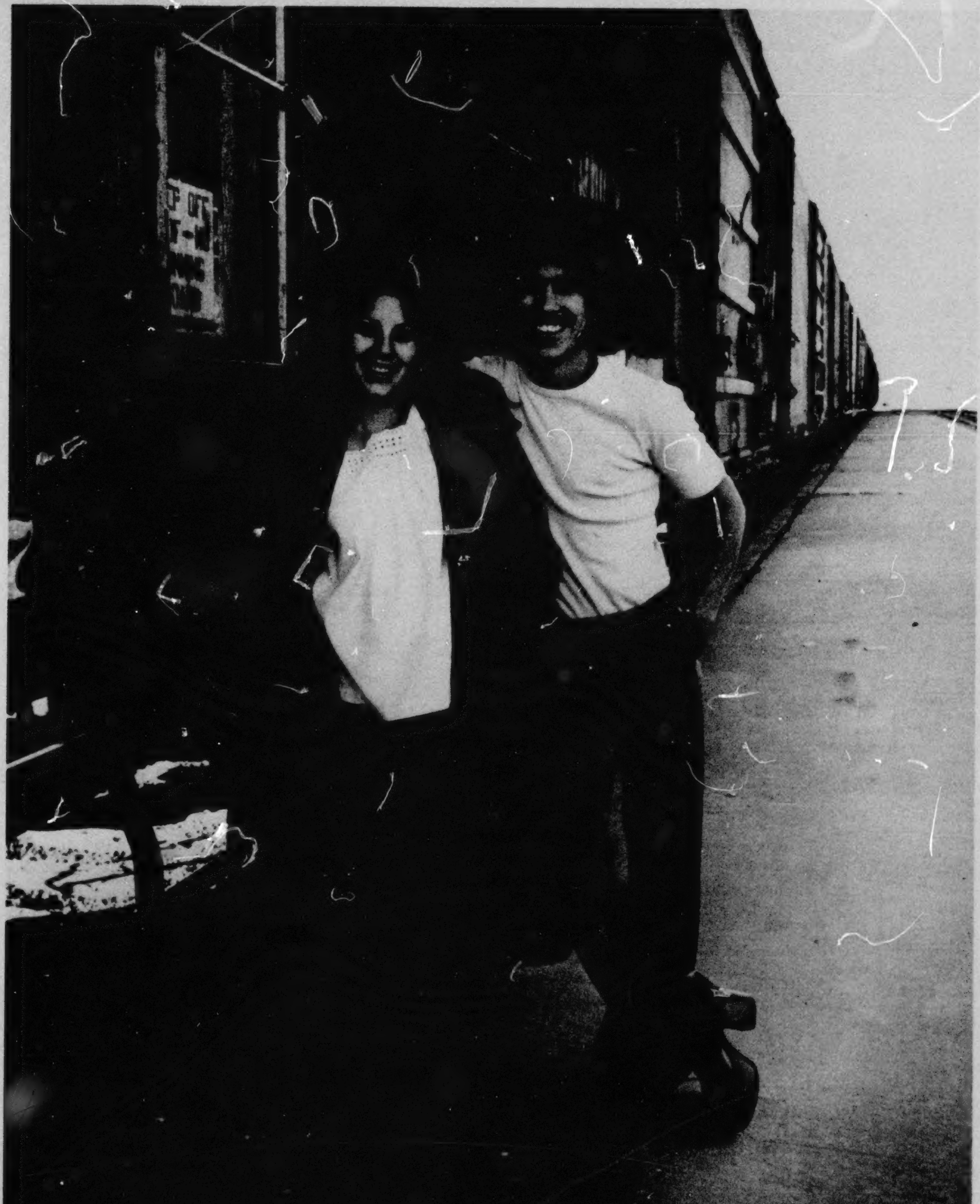
Part Two

ADOLESCENT DEVELOPMENT AND TEENAGE SEXUALITY



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Adolescent Development and Teenage Sexuality

What does the term "pregnant adolescent" mean to you? Obviously it means a girl in her teenage years who is going to have a baby. Simple enough, but what does the term really mean? To understand the pregnant adolescent, you need to understand both the adolescent period and the physical and psychological processes of pregnancy.

The Adolescent Period

In the literature today, much has been written about the period of time between childhood and adulthood that we call adolescence. Adolescence can be described as beginning with the pubescent growth spurt and ending with social maturity. It is a time fraught with emotional upheavals and a set of developmental tasks that need to be accomplished before social maturity can be achieved.

Adolescence is a relatively new concept that our society has imposed upon young persons. Prior to the Industrial Revolution, physical and psychological maturity were achieved at the same time. There was little confusion in most teenagers' minds as to what their roles were and what was expected of them. Extended families gave much support to young persons as they learned to assume their roles as marriage partners and parents. In those days jobs required very little formal educational preparation, and needed skills were learned during the teen years through practical experience. By the age of twenty, many young persons were already married, had families, and were working in jobs that would be their lifelong occupations.

The Industrial Revolution brought changes in the amount of knowledge and skill that were required to obtain satisfying work experiences. Young persons began to delay early marriage and parenting in favor of more education and job preparation. A lag was created, therefore, between the time that physical maturity was achieved and the time that psychological maturity and independence were attained. Confusion was the result!

In today's society the rift between these two maturational times has widened. More and more education and training are expected by today's employers. Young people remain in a dependent state for a longer period of time. Teenagers are regarded as children legally, emotionally, and socially. Society has created adolescence with its resultant emotional turmoil.

Tasks and Characteristics

What are the characteristics and tasks of today's adolescent? For the purpose of this analysis related to adolescent pregnancy, we have divided the characteristics and tasks into twelve areas that invariably interrelate. All these things are shared in common by males and females. For simplification we have used the feminine pronoun in this chapter.

Developing Self-Identity

"Who am I, What am I, and Where am I going?" are the questions that young people ask themselves. Identity is a lifelong struggle that continually changes as we gather new data and incorporate it into our sense of being. The search for self-identity affects much of the adolescent's interaction with peers and family. Self-absorption and/or narcissism characterize the teenager. The adolescent often spends hours alone in her room listening to music, day-dreaming, or staring into the mirror. Many more hours are spent on the telephone or with peers "just talking." Continuity and sameness of experience give a feeling of inner stability that helps to establish the sense of self-identity. The identity adopted by the adolescent is affected by her sex, socioeconomic status, parental attitudes, personality, and peers. There may be strong conformity to or rebellion against the values of those close to her. As you will see, most of the other eleven areas relate directly to the search for identity.

Seeking Peer Acceptance

As a young person advances through the teen years, more and more time is spent with peers while less and less time is spent with family members. There is a tremendous need for a close friend with whom the young person can relate. With her friend she can validate her thoughts and feelings and can gain a sense that someone understands. It can help her to clarify her values and can give her a sense of stability.

Being a member of a group and receiving recognition by peers enhance self-esteem. The symbols that indicate being a part of a peer group include wearing similar clothing, having hairstyles that are the same, using similar vocabulary, and doing what the group is doing. The degree of influence that the peer group has on a young person is somewhat determined by the relationship with parents. Generally speaking, the closer the ties with the family, the less influence is exerted by peers. If a teenager feels she *must* turn to peers for support and identity, the more rigid is her conformity to the rules of the group. Regardless of the teen's closeness to her family, being accepted by peers is extremely important to healthy psycho-social development.

Concern With Body Image

The rapid growth that takes place in the body during adolescence can be confusing to a young person. The beginning of menstruation can be a frightening experience. Awakening sexual feelings add further confusion. Because the young person tends to focus on self, even minor blemishes are of paramount importance. If the young person is either overweight or underweight, she will focus on the imperfections in her body and will fear peer rejection. The more the body contour is like the movie star image, the better the young person will feel about herself. Even though as adults we tell young people, "It's what's on the inside that counts," the outward appearance *does* affect acceptance by peers.

A young person's body image is closely related to sexual self-identity. Our society pushes the "cover girl" image which helps to explain why young women are almost obsessed by diets, hair styles, clothing, and make-up. In an attempt to be sexually appealing, women often define themselves in terms of their height and weight and their hip, waist and breast measurements. Learning to accept body changes and learning to live with one's own mature body are indeed important tasks of adolescence.

Seeking Relationships With The Opposite Sex

During teenage years, young people *do* seek relationships with members of the opposite sex. Young women begin to think about males from a different perspective. They have known males in the roles of fathers, brothers, teachers, etc., and as playmates. Adolescence is the time when young women begin to see males in the roles of boyfriends, lovers, possible sexual partners, and potential husbands and fathers. It is a time of experimentation, including trying on sex roles to find out "what turns a guy on or off." A positive relationship with a member or members of the opposite sex enhances self-esteem and helps to further clarify a sense of identity. "Love" that is experienced during adolescence is often quite intense, yet usually of a transitory nature. Many adolescents "fall in love" several times during the teenage years. Others sustain a "steady" relationship with one partner for a long period of time. Still others want to experience only a casual relationship with members of the opposite sex. Regardless of the degree of intensity in the relationship, the need to feel loved and accepted by a member of the opposite sex is extremely important.

Striving For Independence

To become independent from adult domination is another task of adolescence. There is constant shifting between the need to be a child and the need to be an adult. This area is fraught with confusion for teens and parents alike. The young person may fight with parents to establish her own identity and at the same time may still want and need the support and protection of parents. Parents, too, suffer from mixed feelings about how much control and/or freedom to give. The result is conflict.

Young people do need and want reasonable limitations placed on their actions. Guidelines give them a sense of the boundaries of expected behavior. When parents set reasonable limits, give affection, and show interest in their children, young people tend to move towards independence in a healthy manner. When parent-child relationships are relatively open and conflict-free, teens are more likely to accept and follow parental values. When relationships are poor, young people tend to look to their peer groups for problem solving and for guidelines to behavior. Hence, the values of the group are more likely to be incorporated into the teen's own value system.

Experiencing Mood Changes and Unpredictable Reactions

"What ever happened to our even-tempered, predictable Mary Jane?" lament many parents of teens. The little girl parents once knew has suddenly become a stranger in their home. Emotions during adolescence tend to swing widely due to hormonal changes and to the uncertainty of new feelings. Moods range from euphoria to depression, resulting in unpredictable behavior. One minute the adolescent is accepting, loving, and generous; and the next minute she is rejecting, rebellious, and selfish. There is a low level of tolerance for frustrations.

It is sometimes difficult for adults to be in a teen's environment. Just when everything seems to be going smoothly, the atmosphere changes with a sudden outburst for no explainable reason. The next minute the "waters are calm." For those of you who are parents of teens, we don't need to say anymore!

Experimenting With "Adult" Behavior

The word "adult" is deliberately placed in quotation marks as the behaviors we are referring to may not necessarily *be* adult! Adult behaviors refer to those activities that adolescents may perceive as being performed by adults. Some "adult" behaviors may be described as "forbidden pleasures." These include such things as smoking tobacco or marijuana, drinking alcohol, speeding, and experimenting with various sexual activities. Other "adult" behaviors usually considered more desirable include such things as obtaining a job, doing housework, caring for children, or performing community work. For the adolescent the desire to experiment is as vital as sleeping and eating. It is her means of trying on various roles to see what "fits." Through experimentation some behaviors are discarded, and others are incorporated into the value system. In general, the higher the teen's self-esteem and the closer the family ties, the less she will need to experiment with undesirable behaviors.

Many adolescents think they will be more mature or "adult" if they experiment with the "forbidden pleasures." Indeed, the mass media would have us believe that to be one of the "beautiful people," one must smoke and drink and act sexy! Parental, religious, legal, and other societal pressures, on the other hand, deny young persons the right to experiment with certain activities. The double message is confusing and creates a dilemma for adolescents. Thus, explorations into the "forbidden pleasures," may result in feelings of guilt. On the positive side, such experimentation may confirm that the undesirable behavior has no place in their lives.

Primarily Present-Oriented

Adolescents have a tendency to live only in the present with little consideration of future consequences. For many, a delay of gratification may be extremely difficult, if not impossible. By nature teenagers are risk takers with an "I don't think it will happen to me" attitude.

Some typical manifestations of this type of orientation include driving at high rates of speed because "nothing will happen to me," getting pregnant because "I didn't think it would happen to me!" or spending an entire week's allowance on the first day of the week because "I didn't think I'd need it." One of the major developmental tasks during the adolescent period is to begin to see the cause and effect relationship of one's behavior. It is quite difficult for most adolescents to project realistically what the future may bring; therefore, they may have difficulty setting goals and following through with plans to achieve these goals.

Seeking Successful Experiences

Seeking successful experiences is a task relevant to all stages in life but one that is particularly acute during the teenage years because successful experiences may be difficult to achieve. Adolescents find themselves too old for childish experiences and too young or inexperienced to master adult living. Young people desperately need to achieve some degree of success. Success in male-female relationships, success in becoming a part of a peer group, success in scholastic achievement, success in athletic pursuits — the list goes on and on. Though teens can't be successful in all areas, attaining a sense of accomplishment in at least one area increases the young person's sense of self-worth. With a feeling of achievement in one area, the teenager then feels she may be successful in her pursuit of other goals. As the adage says, "Success breeds success!"

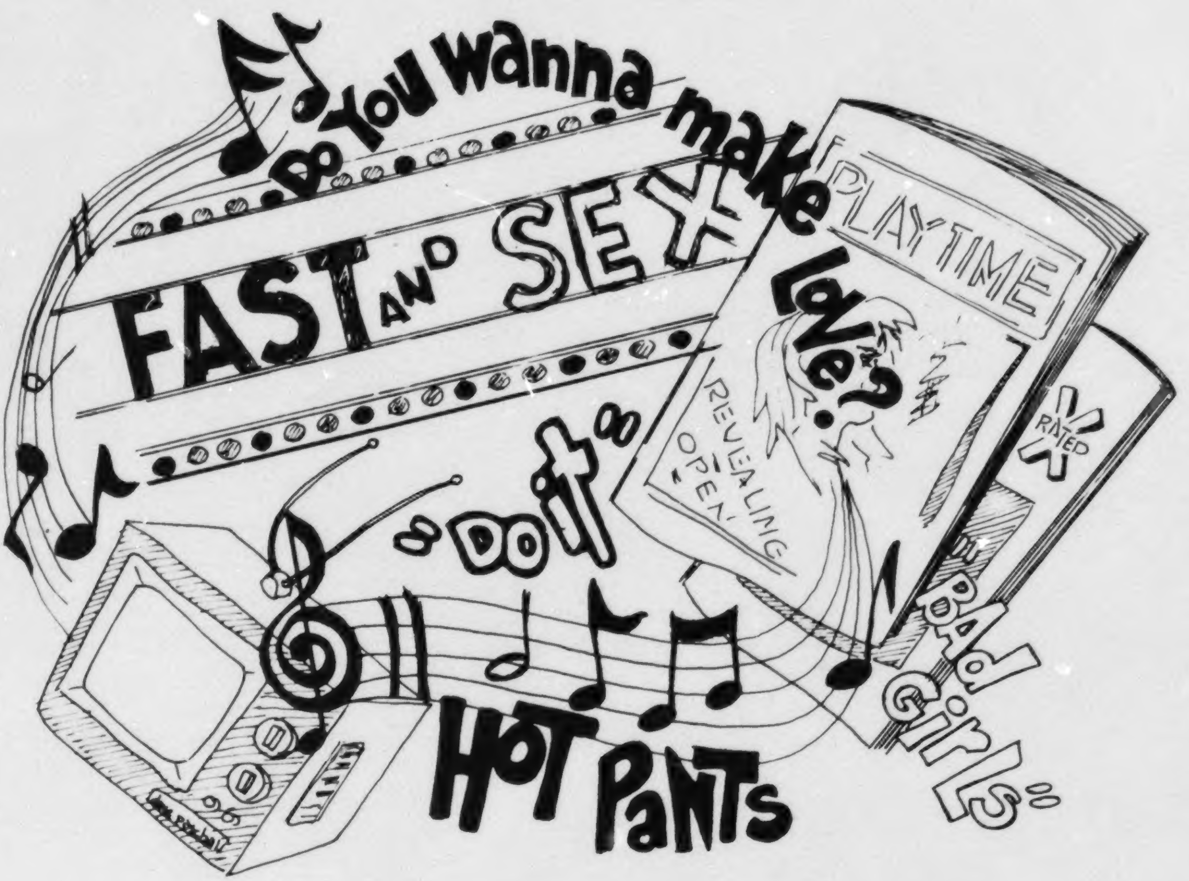
Formulating Sex Role Identity

During adolescence young people formulate their sex role identities. Young men experiment with behaviors classified as "masculine" while young women try on the more "feminine" roles. Our society has customarily assigned certain traits to each gender. Generally speaking, traditional masculine traits have included aggressiveness, athletic prowess, independence, mechanical abilities, leadership, and other mastery skills. Characteristics traditionally accepted as feminine have included tenderness, compassion, dependence, listening, caring, and other social skills. Peer group expectations cause young persons to conform to their respective genders to avoid ridicule. At this stage young people may be resistant to developing the more non-traditional sexual identities.

Status is often conferred on the young man when he "makes it" or "scores" with a young woman. This show of aggressive behavior makes him feel more masculine. Young women have been taught to prepare themselves for marriage by being sexually attractive without being sexually active. After all, everyone knows that "good girls don't do it!" Even though times have changed, the double standard still exists today, encouraging virility for men and virginity for women.

During the 70's, society's expectations regarding masculinity and femininity began to undergo dramatic changes. "Superwoman" began to replace the housewife. Those changing concepts permeated certain groups within our society more than others. Backlash occurred upon occasion. In some ways the changing expectations of society served to make the formulation of sex role identity more difficult for many young people, particularly for young people from traditional minority cultures. Society is giving mixed messages.

Teenagers who become parents may feel a necessity to adopt the traditional role of their sex to demonstrate that they can be successful adults and parents. Hence, new teenage parents are often not receptive to education regarding non-traditional sex roles.



The mass media adds further confusion to sex role identity. Most magazines on the newsstands today exploit women's sexuality. Advertisements often show beautiful women and handsome men dressed or positioned in provocative manners next to the products they are trying to sell. The cigarette ads seem to say, "Smoke . . . and you'll be more masculine!" The cosmetic ads promise, "If you'll only use X-brand make-up, you'll be more beautiful and feminine!" Along with these promises is the implied guarantee that you will also be a happy, more socially accepted person. Also implied is the suggestion that you are *not* all right as you are!

Movie theatres today are crowded with young people watching "R" rated movies. The "R" rating is given to movies that are full of social violence, cruel brutality, foul language, and blatant sex. The so-called "adult" movies of the 1950's and 60's are now shown on prime-time television. The message is clear: "Sex and violence is what's happening."

The top-rated, prime-time television shows are full of innuendos that sex outside of marriage is an accepted practice. Have you listened carefully to the words of the songs that are part of the teenage world? The following letter to Ann Landers was clipped from the newspaper and poignantly describes the music that teenagers listen to today.

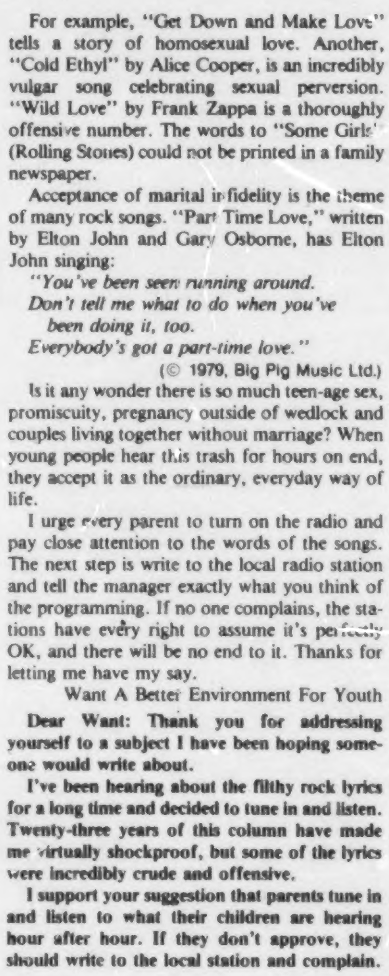
---

ann landers

Dear Ann,

I had attended a conference recently and had my eyes opened. The subject under discussion was rock music.

Most parents have no idea what rock music is all about because they pay no attention to it. If they listened to the lyrics they'd be shocked.



For example, "Get Down and Make Love" tells a story of homosexual love. Another, "Cold Ethyl" by Alice Cooper, is an incredibly vulgar song celebrating sexual perversion. "Wild Love" by Frank Zappa is a thoroughly offensive number. The words to "Some Girls" (Rolling Stones) could not be printed in a family newspaper.

Acceptance of marital infidelity is the theme of many rock songs. "Part Time Love," written by Elton John and Gary Osborne, has Elton John singing:

"You've been seen running around.
Don't tell me what to do when you've
been doing it, too.
Everybody's got a part-time love."

(© 1979, Big Pig Music Ltd.)

Is it any wonder there is so much teen-age sex, promiscuity, pregnancy outside of wedlock and couples living together without marriage? When young people hear this trash for hours on end, they accept it as the ordinary, everyday way of life.

I urge every parent to turn on the radio and pay close attention to the words of the songs. The next step is write to the local radio station and tell the manager exactly what you think of the programming. If no one complains, the stations have every right to assume it's perfectly OK, and there will be no end to it. Thanks for letting me have my say.

Want A Better Environment For Youth

Dear Want: Thank you for addressing yourself to a subject I have been hoping someone would write about.

I've been hearing about the filthy rock lyrics for a long time and decided to tune in and listen. Twenty-three years of this column have made me virtually shockproof, but some of the lyrics were incredibly crude and offensive.

I support your suggestion that parents tune in and listen to what their children are hearing hour after hour. If they don't approve, they should write to the local station and complain.

It is no wonder that our young people are confused about their sex role identities and about acceptable forms of sexual activity. Parents say, "No, wait 'till marriage," yet society condones the use of sexual exploitations by the mass media. The double message makes it extremely difficult for young people who are actively undergoing identity crises to decide what is right for them.

Developing a Value System

Developing a set of values by which to live is closely linked to defining one's sexual role and behavior. In the struggle to gain independence, adolescents often rebel against parental and societal values. Experimentation with "adult" behavior is a vital part of the process of developing a personal set of values. Young people must adopt values that are meaningful for them. Even in families where there is closeness and understanding between parent and teenager, there may be rebellion and rejection of parental values. It is interesting to note, however, that most young people eventually adopt values quite similar to those of their parents. The search for a philosophy of life is easier for adolescents when they have patient and understanding persons in their environments who can act as sounding boards as they sort out these issues of values and behavior.

Concern With Choices of Career and Lifestyles

The adolescent who has achieved some degree of success and self-confidence in her ability to master her environment will have more energy to devote to the pursuit of career and lifestyle choices. There is a tremendous push by parents, educational systems, and society for young people to establish occupational goals. They may be forced to put on masks that are unreal because they are not sure what they want for themselves. Such demands cause conflict. The educational demands of our technological age may make adolescents feel that their choices are limited. They may feel bombarded and overwhelmed with all that it seems necessary to know. Rebellion may be the result because young people want to hold onto their rights to make choices.

Adolescence is a stressful period in the lives of most young persons (and their parents!). The goal is to attain emotional maturity, which has been defined by the nursing leaders in NAACOG As "The attainment of a harmonious relationship between self and environment that allows for constructive work, heterosexual relationships, and generativity." Perhaps this definition can be expanded somewhat. The emotionally mature individual is able to formulate satisfying interpersonal relationships with members of both sexes.

Adolescent Sexuality

In describing the characteristics and tasks of adolescence, we have discussed some of the aspects of adolescent sexuality. Adjusting to body changes, acquiring an appropriate sex role identity, and developing a value system are all a part of adolescent sexuality. Sorenson, in 1974, compiled data on the sexual activity of 411 young persons. Zelnik, Kim, and Kantner compared statistics of sexually active teens in the U.S. from 1971-1976. The following statistics and discussion are from these two studies.

Statistics on Adolescent Sexual Activity

Zelnik, Kim, and Kantner report that 20 percent of U.S. females have had intercourse by the age of sixteen, and 60 percent have had intercourse by the age of nineteen. Almost all of the sexual experiences are premarital. By the age of nineteen, 30 percent of the sexually active Anglo girls and 50 percent of the Black girls get pregnant premaritally. Methods of birth control are not used by most young women at the time of their first intercourse. The first encounter most frequently takes place in the home of the girl or the boy. In comparing the 1971 and 1976 statistics, it is clear that premarital sexual activity among teenagers is on the rise.

Meaning of Sexual Relationships

In his study Sorenson sought to find the meaning of sexual activity to adolescents. He recognized that there is a conflict between teens and their parents that results from teenage sexual activity. He said that the conflict results from the young person's search for self-identity and personal freedom and from the parent's reluctance to let go.

The inability of parent and child to communicate about sexual matters adds to the conflict. Most adolescents feel that they cannot talk freely about sexual matters with their parents because they are unsure of what their parents want them to know about sex. If the adolescent appears either too knowledgeable or too naive, the parent tends to be distrustful and fearful of the young person's sexual behavior and the possible consequences.

Sorenson suggested that there are three factors separating today's teens from adult society: "the rising use of situational ethics in place of dogmas of morality; new forms of sexual relationships; and a generational consciousness and chauvinism among today's adolescents." He found that the majority of sexually active teens believe in situational ethics, not in what's morally right or wrong but what they believe is the best thing to do in a given situation. In other words, if it seems right to have sex in a given situation, they do it! For those who did experience guilt from having had sexual intercourse, he found that the guilt resulted more from the deception of people who trusted them rather than from the sexual behavior itself.

Sorenson also found that many young people believe that sex is a natural part of a heterosexual relationship. The most important aspects of sexual activity the teens cited were the personal intimacy and sharing it permitted between two people. Sorenson felt that many adults subscribe to the puritanical ethic in matters of sex. From this viewpoint sex is seen as a part of marriage and not necessarily as the natural outcome of an intimate relationship between two people.

Sorenson described the generational consciousness of the teens he studied. He said that they identify with their own generation and tend to believe that their values differ from and are superior to those of the older generation. The teens tended to feel that they were better qualified to decide what was best for them than were their parents. The majority of young people believed that society's rules about sex were for society's own benefit rather than for their own. They also believed that one should not have to get married to have sex.

The Sexually Inexperienced Teen

Sorenson also studied the differences between the inexperienced teen and the one who is sexually active. He found that the inexperienced teens tended to be

1) less confident that they could get along well on their own;
2) ambivalent about whether they function as children or adults;
3) less willing to state that adolescents were superior to adults;
4) much more in consensus with their parents on matters concerning sex;
5) less likely to smoke marijuana;
6) guided by their religious beliefs;
7) comfortable about their inexperienced status, viewing their lack of sexual activity as their own choice;
8) just not ready for sex.

You can surmise from all that has been said some of the reasons for sexual activity among teenagers: the need to prove one's femininity or masculinity; to exert independence from parental controls; to experiment in finding one's own values; to conform to pressures from the peer group; to experience intimacy with another person; and last, but not least, to conceive and bear a child.

Why Do Teens Get Pregnant?

We are frequently asked this question. The general assumption is that with birth control methods readily available today, there is neither reason nor excuse for a young woman to get pregnant. That rationale is very clearly adult thinking and does not take into account the fact that adolescents do not necessarily think in an adult "cause and effect" manner.

Let's look at some of the reasons for lack of contraceptive use among adolescents.

1) Lack of knowledge about the methods available and how to obtain them
2) Fear that the method will be discovered by a parent
3) Inconvenience in obtaining and consistently using a method
4) Belief that using a method will interfere with the spontaneity of sex
5) Belief that contraceptive use will diminish sexual pleasure
6) Belief that the use of a method implies premeditated sex, which in turn implies "bad girl," while spontaneous sex is fate or "just a mistake"
7) Risk taking . . . "It won't happen to me"
8) The conscious or unconscious desire to get pregnant to prove femininity, self-worth, or adulthood

Working With Parents of Teenagers

You may find yourself working with parents of teenagers as well as with the young people themselves. Parents often ask what they can do to facilitate the growth of their children and to prevent problems such as adolescent pregnancy from occurring. Throughout this chapter we have mentioned that a close relationship between parent and teenager can lessen some of the negative impact of adolescent behavior. Open communication can help, but we do not mean to imply that close relationships will *always* prevent experimentation or rebellion. Parents should not feel they have failed when such behavior occurs.

Adolescent pregnancy, experimentation with alcohol and drugs, and other behaviors of questionable value occur in all types of families, even when close parent-teen relationships exist. When a young woman does get pregnant, the parents may experience feelings of guilt, shame, and isolation and may wonder "Where did we go wrong?" Your goal is to help the parents in a supportive manner to work through these painful feelings without increasing their sense of failure. With feelings of guilt resolved, the parents are then in a position to facilitate the development of the support network which the young person so desperately needs.

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Part Three

TEENAGERS
AS
PARENTS

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Teenagers As Parents

It is our belief that parenting begins prenatally when a woman learns that she is pregnant. The way she views the developing fetus within her body and cares for herself during pregnancy influences the quality of parenting she will give her child after birth. In the last chapter we examined the characteristics, developmental tasks, and sexuality of adolescents. To better understand teenagers as parents, we will now examine the tasks of pregnancy and the development of the maternal role.

Psychological Tasks of Pregnancy

During pregnancy there is a set of psychological tasks through which every pregnant woman moves to incorporate the maternal role into her self-system. The tasks follow a logical order but do not necessarily follow a certain time frame. The mother-to-be may alternate from one task to another; but it is generally agreed that all women must in some way accomplish the emotional work of pregnancy because it affects the quality of their future relationships with their children.

Basically there are four developmental tasks of pregnancy. They have been given different labels by different persons describing the same tasks. The first task can be called pregnancy validation or the acceptance of the reality that pregnancy does exist. Usually this first task is achieved during the first trimester once pregnancy is confirmed. Ambivalent feelings characterize the adjustment period.

The second task involves the incorporation of the growing fetus into the woman's body image. The task of fetal embodiment is achieved when a woman recognizes that the fetus does exist as a part of her body. Often this recognition occurs during the second trimester when fetal movement is experienced. The mother-to-be usually focuses on her own feelings and feels satisfied that she is pregnant.

The third task, fetal distinction, occurs when the woman recognizes the fetus as separate from herself with an identity in his own right. This distinction may occur in the second or third trimester of pregnancy. The woman focuses on her future role as a mother and begins preparations for the assumption of her new role. She will often review her relationship with her own mother and may be very dependent upon her for emotional support.

As the woman approaches the time for labor and delivery, she prepares herself for separation from her unborn child. She will become anxious to be through with labor and delivery. Final plans are made at this time about how she plans to "mother" her child. She has fantasized her own role, and she has fantasized how the baby will look and act. She becomes ready to assume the role of the reality mother.

The final task occurs after the child is born as the mother goes through the role transition of becoming a care-giving mother. This role transition is easier when the fantasized child matches closely with the real baby.

Like any expectant mother, the pregnant adolescent must also go through the maternal tasks. For her the tasks are often more difficult for a variety of reasons. There may be a lag in the achievement of each task if there is a delay in the acknowledgment of the pregnancy. Many pregnant adolescents are not aware of the fact that they are pregnant either because of lack of knowledge or because of denial. Denial is prevalent, resulting from concern over the reactions of significant people in her life. There may be the belief that through denial the pregnancy will "just go away." Part of the process of accepting the pregnancy is the "grief" work that must be done over giving up previous lifestyles. The pregnant adolescent has difficulty in imagining giving up school, dances, and other aspects of her former life.

If the adolescent enters the second trimester still denying her pregnancy, she may have difficulty accepting the fetal movements as real or as reassuring. In reviewing her relationship with her own mother, she may still feel the need to be "mothered" herself. The question may also arise as to who will "mother" the unborn child. Resolution of this problem should take place prior to delivery, if possible, to prevent future conflicts in the mothering of the child. There is also a need for pregnant women to be associated with others in the same condition. If the young woman is in a program with other young expectant mothers, this need can be met.

When these early tasks have been delayed, there may be a delay in the young woman's preparations for the separation from her unborn child. If she has received much positive attention during her pregnancy, she may be reluctant to give up her pregnant condition. She may need help in projecting into her future role, to make preparations either for motherhood or for releasing the child for adoption.

Our experience with pregnant adolescents has shown us that many young women move through the psychological tasks of pregnancy with little difficulty. The less negative the feelings were at the beginning of pregnancy, the easier it seems to be for the maternal tasks to be accomplished.

Even when the young woman intends to release the child for adoption, it is still necessary for her to move through these same psychological tasks. Because she will not be assuming the actual maternal role, a certain degree of "grief" work is necessary and desirable for her to be able to bring resolution to the pregnancy. If she has had difficulty in accepting the reality of her pregnancy, she may have difficulty in facing the reality of the loss of the child.

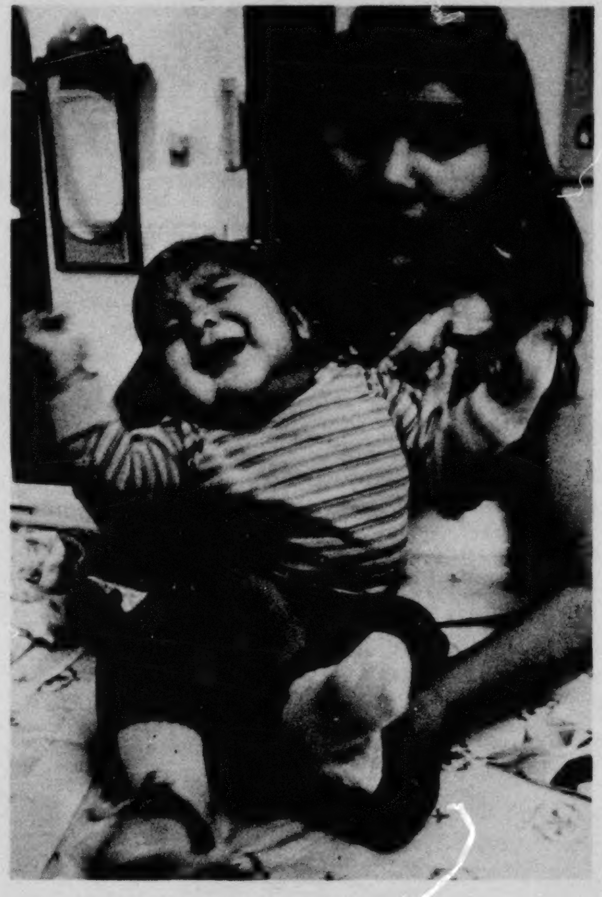
Maternal-Infant Attachment

Closely associated with these psychological tasks of pregnancy is the process by which the mother forms a bond with her child. Simply defined, this maternal-infant attachment is a psychological and emotional bond that is formed between the parent and child. The formation of this bond begins prenatally and continues with each act of mothering. The quality of the maternal-infant bond is affected by the way in which the mother accomplishes the tasks of pregnancy. It is also affected by her early interactions with the infant.

For decades professionals working with mothers and infants have noted behaviors indicative of the development of a very strong attachment quite early in the relationship. In the 1940's Spitz studied development during the early months of life. He noted severe physical, mental, and emotional deterioration in previously normal infants who were suddenly separated from their mothers at the age of six months. These infants deteriorated quite rapidly after the separation and frequently died.

More recently Marshall Klaus began to examine maternal-child behaviors cross-culturally and found similarities in the behaviors of mothers towards their infants. Klaus noted a reciprocal relationship between mother and newborn with each contributing to the formation of the relationship and each being reinforced by the other.

From the infant's point of view, the establishment of an attachment with at least one significant person is considered crucial. This early attachment is seen as the basis of his sense of well-being, profoundly affecting his physical, mental, and emotional development. Indeed, this attachment is necessary to his very survival. Many researchers are linking the failure-to-thrive syndrome with the failure to develop an adequate attachment.



There are many factors which influence a parent's ability to attach to an infant. The ability to love another human being probably goes back to one's own early days as a small child and the formation of a significant relationship to another person (usually the mother, but not necessarily). When an infant has at least one person offering consistent warmth and affection, the ability to form close attachments usually develops.

The way the mother feels about herself during pregnancy and at the time of the child's birth seems to affect her attitude toward the child. If she has accepted the pregnancy and views it as a positive experience, her self-esteem may be enhanced. In this case she may find that the assumption of the mothering role is an easier task. If in contrast, pregnancy has been a negative or painful experience for her, her self-esteem suffers; and, consequently, her relationship with her child may suffer.

In addition, the circumstances of the woman's life during the childbearing experience may also have a significant effect. Such factors as social isolation, loss of her partner, economic crisis, illness, or lack of parental support can seriously deplete the young mother's stamina and again damage her self-concept. If her own emotional stores are depleted, she will be less likely to have much to give in the nurturing role.

The labor experience itself is also cited as important to the establishment of strong ties with the infant. The mother who feels good about her experience and her own role in the birth of the child will be far more ready to take on the nurturing role. If, for some reason, the woman feels that she was inadequate or if labor was severe or prolonged, she may need some assistance in putting that experience into perspective.

As soon as the child is born, the mother makes a comparison between the actual child and the fantasized one. As mentioned before, she can usually make the transfer if her expectations are met. If her expectations are not met, such as in the case of deformity or prematurity, the mother first needs to grieve over the loss of the fantasy child before she can accept the new one. This disappointment may also occur if the child is not the hoped for sex, if he resembles someone she dislikes, or if he fails in any way to live up to her fantasy.

The infant's responsiveness appears to be crucial for the reinforcement of the parent and, thus, for the establishment of the parent's desire to nurture the child. Each newborn is unique and will respond somewhat differently. *The mother's perceptions of the baby's responses are crucial.* She wants to know whether the baby loves her and whether he likes what she does for him. Consequently, the baby that nurses well, can be consoled, and looks into his mother's eyes will provide his mother with the positive reinforcement she craves. If, on the other hand, the baby is excessively irritable or has difficulty opening his eyes, the mother may feel he is rejecting her.

This process of bonding is an evolutionary one. Each time the baby responds favorably to his mother's care, she will sense that she is doing her job well and will be motivated to do more. If the infant responds in ways that she perceives as rejection, she will feel incompetent and be less inclined to make contact.

It is essential to remember that a young mother's ability to nurture is often directly related to the amount of nurturing she herself has received and continues to receive. The teenage mother may, indeed, be experiencing emotional or economic deprivations, lack of support, and lowered self-esteem. It is essential that those who work with her offer sincere support, acceptance, and confidence in her ability to cope. The long-standing message of the self-fulfilling prophecy definitely applies here. *She can if she believes she can.* If those who are her teachers and caregivers send her "can't" messages, the vulnerable young mother will certainly pick them up. If we keep in mind some basic principles relating to the establishment of a positive relationship between mother and child, there may be much that can be done to facilitate the process. Throughout the remainder of this book, we will offer suggestions on how you can facilitate the process of parent-infant attachment.

The Teen Parent

As mentioned earlier, approximately 90 percent of the young women who give birth elect to keep their children and rear them. This high percentage is a subject of frequent controversy, as many will argue that most teenagers are destined to be less-than-adequate parents. There are certainly valid points to be made on both sides of this issue, and it is one that will probably never be totally resolved. The fact still remains that these young women are making choices for their lives and the lives of their children, and the choice most frequently made is motherhood.

In many ways teenage parents are very much like any new parents. In our society there is still little provision made for preparing for the role of parenthood. Those who live in an extended family situation may have some knowledge of and experience in child care. Many young people do not have such an opportunity, however, and they lack such knowledge and skills.

First-time parents are often fearful of the parenting role, and teen parents are no exception. Such natural fears may be magnified by the expectations that as teenagers they will fail. These expectations are communicated to them clearly in remarks such as, "I don't know how she can do it; she's just a baby herself!" and, "What can you expect from children rearing children?"

Teenage parents have the advantage of being young and strong. Throughout the history of the world, women have begun childbearing during their teenage years. Less than a hundred years ago, in fact, women in the United States were married and became mothers at a very young age. However, our society has changed significantly in the last century. Adolescents are now dependent educationally, financially, and emotionally for a much longer period of time.

Because of this stage of adolescent dependency, teenage parents are unique in some ways. The stages of adolescent development may conflict significantly with the experience of pregnancy and with the parenting role (see Figure 1, page 31). At times this conflict between the teen's needs and those of her child may become intense. During these times the mother experiences guilt and confusion. Many young adults are grappling with a low sense of self-worth. In addition to feelings of inadequacy related to parenthood, there are problems related to the circumstances surrounding the pregnancy itself. Finally, pregnant teenagers tend to expect to rear "babies." They are often more prepared emotionally to care for a small, docile infant than for a self-determined toddler.

The teenage parent may have unique challenges related to childrearing because of living conditions. If the teen is young and lives at home, she is likely to still be financially dependent upon her parents. This dependency places her in the unique position of still being responsible to her own parents. Her parenting behaviors may be under constant, close surveillance and may be the subject of criticism. In addition, her own parents may reinforce her sense of inadequacy and dependence by taking over the parenting of her child. These living arrangements may mean the young mother is seldom alone with her child. On the other hand, she may have little or no opportunity to be completely away from the child.

If a young couple is living together in the home of either set of parents, they may feel their relationship is under close scrutiny. This feeling can inhibit them in working through their interactions and in learning to behave spontaneously with one another. It may be difficult for them to adopt their roles as husband, wife, mother, and father when in many ways they are still so dependent upon their own parents.

Families in such situations may need assistance in learning to relate sensitively to one another. Grandparents may need help in understanding the importance of the young parent's development of a strong, consistent relationship with the child. Family members may need help in discovering ways to meet their own needs as well.

Young parents may still feel the need to be emotionally dependent upon an adult. In some cases emotional support is available from one or more members of the extended family or from a close friend. When such a person is not available, the young woman may develop an attachment with a helping person — a teacher, counselor, health care provider, etc. The support of such a person can positively influence her ability to parent as well as facilitate her own development.

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Figure 1: Characteristics and Needs of Adolescents and Areas of Potential Conflict Related to Pregnancy and Parenthood

THE ADOLESCENT IS

TITY
SEE
WITH

PREGNANCY

- Pregnancy can either enhance or confuse self-identity.

- Social isolation may result as they are neither "typical" adults nor "typical" teens.
- Friends may abandon them.

- Rapidly changing body is unlike peers.
- Physical discomforts may confuse the perception of the body.

- Pregnancy may influence the outcome of the relationship with the father of the baby and may influence her perceptions of future relationships.

PARENTHOOD

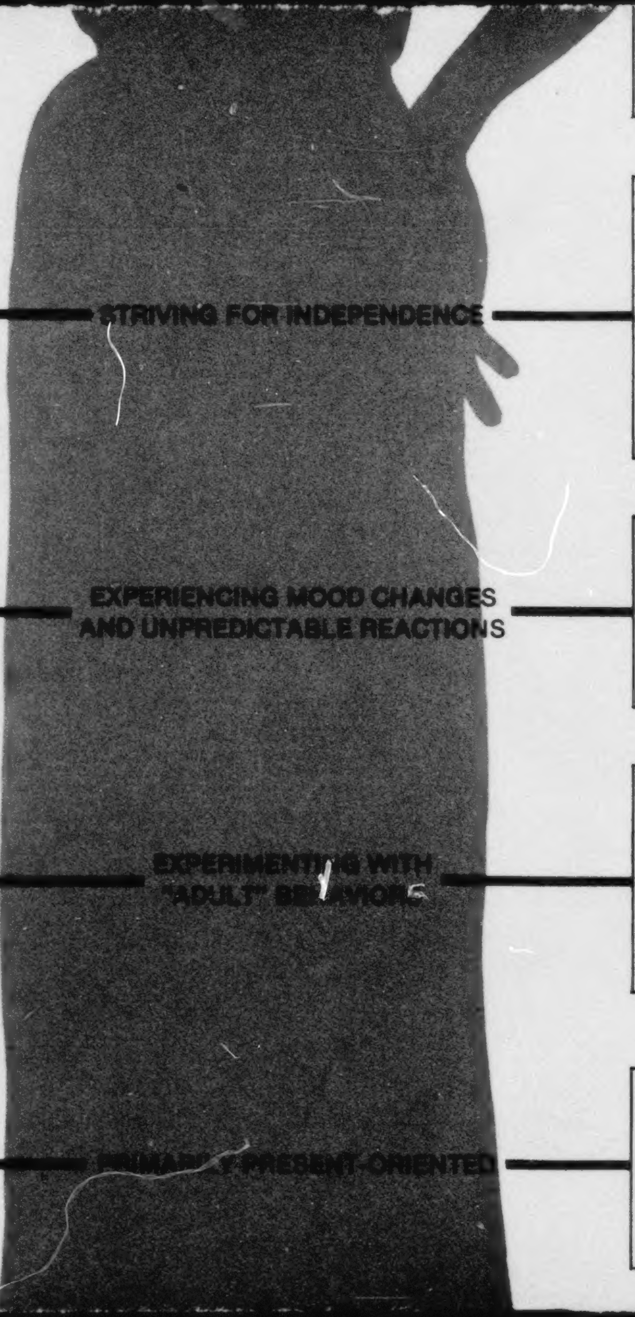
- Child is also self-absorbed and needs consistent care.
- There is a need to identify with parental role.

- Social isolation may result as they are neither "typical" adults nor "typical" teens.

- Adaptations must be made to the altered physical characteristics resulting from pregnancy.

- Concern for male-female interactions may take precedence over parenting role.
- Opportunities to seek relationships with males may be limited.

- Male reactions may be influenced by the fact that they know she has been sexually active.



STRIVING FOR INDEPENDENCE

- Pregnancy may make her more emotionally, financially, educationally, and medically dependent.
- The dependency of pregnancy may interfere with the establishment of her autonomy.

- Mother may be dependent on adults for assistance.
- Child is dependent upon the mother.
- Financial restraints may curtail independence.

EXPERIENCING MOOD CHANGES AND UNPREDICTABLE REACTIONS

- Emotional upheaval may be compounded by the mood swings of pregnancy.

- Mood changes may interfere with consistency in parenting.
- Demands and moods of the child may add pressure and stress.

EXPERIMENTING WITH "ADULT" BEHAVIORS

- Use of alcohol, drugs, and tobacco adversely affects the outcome of the pregnancy.
- Contracting a venereal disease is a possibility.

- The desire to experiment with adult behaviors may take precedence over the desire to parent.
- Parenting may be seen as an adult behavior.

PRIMARILY PRESENT-ORIENTED

- Here-and-now time orientation may inhibit progression through the maternal tasks.
- There may be difficulty in seeing the relationship between present actions and future outcomes.

- Parenting skills often are not learned in advance of the need.
- There may be difficulty in planning for the future.

- Significant others may equate pregnancy with failure. - Pregnancy may be viewed as a means of having a successful experience.	SEEKING SUCCESSFUL EXPERIENCES	- Rejection or negative expectations from significant others may interfere with her ability to parent. - Education may be interrupted or terminated. - Criticism may inhibit her sense of adequacy as a parent.
- Sense of femininity may be reinforced or confused. - She may be less likely to explore non-traditional female roles	FORMULATING SEX ROLE IDENTITY	- Because she is a mother, she may feel her choices and decisions regarding her female roles are limited.
- Pregnancy during the teenage years may conflict with her personal, family, and/or religious values.	DEVELOPING A VALUE SYSTEM	- Single motherhood or forced marriage may conflict with her values.
- Preparation for motherhood may take precedence over career choices.	CONCERNED WITH CHOICES OF CAREERS AND LIFESTYLES	- Financial demands, need for day care, and/or lack of training may limit choices.

Adolescent needs and characteristics listed above are those observed among the general U.S. population. Variations do exist in some individuals and within sub-cultures. The purpose of listing areas of potential confusion is to alert the helping person to the possibility of conflict. Seldom does a young mother experience, problems in all of these areas. The degree to which problems are experienced is dependent largely upon the adolescent's level of maturity at the time of pregnancy as well as upon the nature of her support system.

Developed by Catherine Monserrat and Linda Barr.

Part Four

SO YOU WORK WITH PREGNANT TEENAGERS

So You Work With Pregnant Teenagers

Before we began writing this book, we decided to find out what people in the field wanted to know. We sent one hundred questionnaires to individuals and programs who use *Teenage Pregnancy: A New Beginning* in their work with pregnant adolescents. We received responses from all over the country, from helping persons in a variety of fields. Their questions and suggestions were very much appreciated. This section is dedicated to responding to some of their specific concerns.

How Do Teenage Women React to the News That They Are Pregnant?

Initial reactions to pregnancy may run the gamut from pleasure to panic. Most young women report that they really had not expected to become pregnant. For many there is a sense of maturity, a feeling of having stepped into womanhood. Even though at the conscious level, a young woman may be "shocked," she may have had a subconscious longing for a child. She may secretly hope that this pregnancy will somehow provide an escape from an unhappy home situation. Now she will *have* to be treated as the woman she feels she is.

At the same time there is fear. How will her boyfriend and parents react to the news? What will happen to her? To whom can she turn for help? Many young women consider running away in the hope of escaping confrontations with their loved ones. A more common approach is to delay revealing the information for as long as possible. The denial may be strong enough that the young woman avoids accepting the truth for an extended period of time. For these reasons she may be well into the second trimester before seeking prenatal care or enrolling in a teen mother program.

Sometimes a young woman prefers to withhold the news of her pregnancy so that she can first work through her own reactions and decisions. She may feel that telling her family and friends will invite a deluge of advice and pressure that will confuse her further. These feelings, of course, may be well grounded. The feasibility of keeping her pregnancy a secret will depend upon the young woman's age, level of independence, and relationships with her family. A younger teen living at home with her parents may have fewer options available to her than one who is older, employed, and nearing the completion of high school. Each situation must be viewed as unique with its own set of variables and circumstances.

What About Reactions of Family Members?

Many teenagers expect that the news will "kill" their parents or that their parents will react by "killing" them. They are fearful of becoming a disappointment and of being rejected. Parents' reactions do vary widely. Some are more accepting than others. A few are punitive and rejecting.

Parents are initially shocked, angry, and hurt. They may feel guilty and wonder if they have somehow been at fault. For the most part, the parents we have worked with have shown genuine concern for the well-being of their daughters (and sons) and a sincere desire to be supportive.

Parents and other family members may need assistance in sorting out their feelings and in developing methods of offering support to their teens. For this reason we encourage you to find ways of involving parents in your program. We have had particular success in organizing parent groups that are based upon service to our program and upon education about trends in childbirth and parenting. Once they have become comfortable in such groups, parents begin to share their concerns more openly with one another. Those who participate in such activities report that the support and sharing was valuable. Many parents have continued their involvement with our program after their teenagers have completed their stay with us. They have been valuable in organizing new groups. Some have served as members of our board.

What About Young Fathers?

The decision of whether to involve the baby's father may be a difficult one for the expectant mother. If the young people are still seeing one another, the decision of whether or not to marry may cloud their minds. If the young woman is angry with the baby's father or if they are no longer together, she may feel he has no right to be involved. The legal implications of paternity are continually changing. They may vary from state to state. It will be of vital importance that you familiarize yourself with the laws in your state related to the rights of young fathers.

The news of the pregnancy may be just as confusing for the young man as it is for the girl and her parents. He may want to become involved but may not know how. He may experience many of the same initial reactions as the young mother: feelings of pride, maturity, fear, denial, etc. If his initial reactions are not what the young woman hoped for, she may interpret his reactions as proof that he does not love her, adding further confusion to their relationship.

The young father will need help in sorting out his feelings and in making plans for the future. We have found that many are reluctant to make the initial contact with our program. Often the best way to reach them is through the young women. Activities designed for couples, such as classes in childbirth and parenting, are usually well attended. Once the initial contact has been made, it becomes easier to offer further services to teen fathers.

How Do Pregnant Teenagers Feel About Attending Special Programs?

When a young woman first enters a pregnant minor program, she may have a sense of disorientation or lack of belonging. Many tell us that the first week or so is the most difficult. They may feel that they don't belong in a special school. They may feel lonely and isolated because they have left their friends and teachers behind. Many say they expected the girls in the special program to be "bad" or "weird."

Once they have made the initial adjustment, however, most young women report that they enjoy participating in a program specially designed to meet their needs. They enjoy the contact with others whose experiences are similar. They also say that they appreciate the friendliness and support of the staff. In specialized school settings, they say that they benefit from the small, success-oriented classes and from the individualized instruction they receive. In fact we have watched hundreds of young women blossom as a result of their experiences in a supportive environment.

Are There Any Special Considerations to Remember When Working in a Classroom Setting?

If you are teaching in a classroom setting, you may wonder what you can expect from your students. Chances are your students will be at different age, educational, and maturity levels as well as at different stages in their pregnancies. You may find that even in the same student there is a variance in interest levels. We have found that many young women show an interest in school for the first time in their lives! All of a sudden they see a purpose in school and feel a need for education. Many students enter our program with previously poor grades. These poor records are not an indication of the level of performance that can be expected. It is not at all unusual for D and F students to earn A's and B's in the new setting. Smaller, success-oriented classes plus the individualized attention our students receive contribute to the higher grades they earn. There are other young women, however, who seem to need socialization and supportive services that our program provides far more than they need the education at this time in their lives. Their lack of academic interest can be frustrating to teachers.

Flexibility in the classroom setting seems to be an important key to successful teaching. Because of the various differences in students, lesson plans are frequently individualized to meet the differing needs. Flexibility is also necessary because of the erratic attendance of some students.

Pregnant students seldom present discipline problems. The most common complaint of teachers in special programs for pregnant minors is that of absenteeism. Health and emotional problems may prevent a pregnant student from attending on a regular basis. As a result teachers find it difficult to provide continuity of learning for all students. Teachers must find creative

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ways to provide alternative learning experiences for make-up work. Our teachers have found that individual research on handout questions is one of the most effective ways to provide for continuity of experience.

Nina DeBerry, a history teacher on our staff, summarized her advice in this manner:

> Hang loose! You can't change the world overnight. You need to know your material, you need to be constantly flexible and review and improve teaching techniques (what works for one may not work for the next), you need to like your work and the girls and sell them on your field. You need to encourage and motivate.

What Are the Qualities That Will Enhance My Effectiveness in Working With Pregnant Adolescents?

To answer this question, we asked the staff members at New Futures School to respond with the qualities that they have found to be effective. These are the ones they named:

(1) Understanding, compassion, empathy

These caring qualities are essential to any helping relationship. A warm approach that says "I care about you" helps to establish a good rapport.

(2) Good self-image

The person who feels good about him/herself functions with a sense of internal comfort. A sense of well-being allows a person to be natural and instills confidence in others.

(3) Enthusiasm and friendliness

An eager interest in and friendliness toward young women are vital qualities that can enhance effectiveness. Enthusiasm can give the psychic strength needed to prevent you from becoming emotionally drained.

(4) Non-judgmental approach

Accepting young women as they are is vital to a supportive relationship. One of the staff added: "Drop prejudgments — there are so many ways to be a 'typical' pregnant teen; every assumption I've caught myself in has turned out to be false for many girls."

(5) Sense of humor

Being able to laugh about disgruntling situations can help prevent depression. Young women often find it easier to relate to a person who can laugh at his/her own mistakes. One word of caution— *never* laugh *at* one of the young women with whom you work.

(6) Patience

Patience is indeed a virtue needed in working with pregnant adolescents. Patience will help you deal with the frustrations experienced as a result of a young person's repeated questions, apparent lack of interest in learning situations, lack of responsibility, etc.

(7) Honesty

An ability to "own up" to your own feelings and/or limitations helps a young person to be able to be open and honest in return. If you experience anger or frustration with certain young people, it may be helpful to voice your feelings in a non-threatening, honest manner. Covering up feelings of hostility or anger may cause a wall to be built in the relationship. You must be careful, however, that in the name of "honesty" you don't lose control of your feelings and lash out. Another caution to keep in mind is that honesty does not mean giving advice.

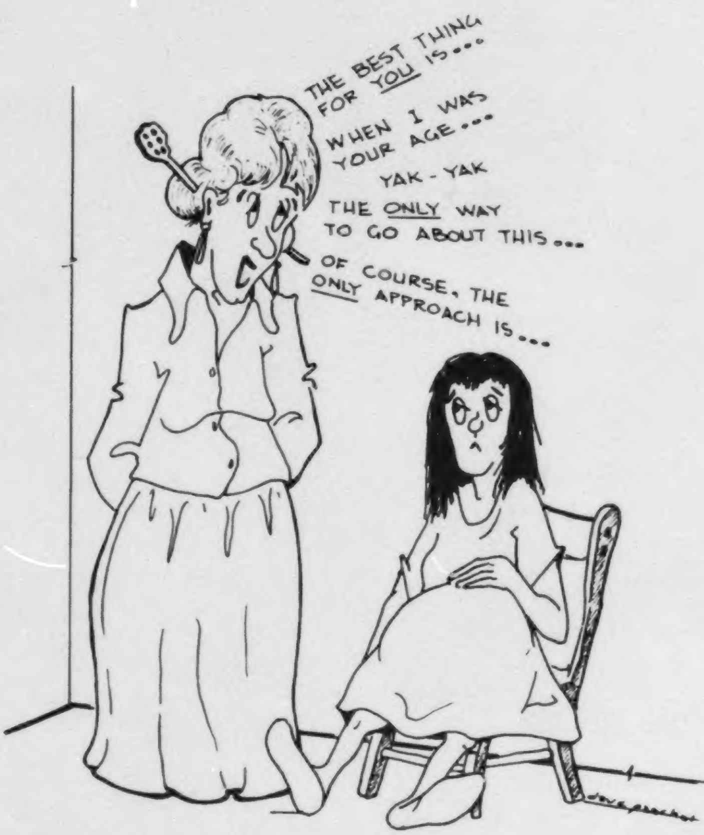
(8) Ability to refrain from giving advice

There will be times when you have to bite your tongue to keep from saying "I think you should . . . ." Remember that the advice you want to give is from *your* perspective and not from the viewpoint of the young woman with whom you are working. Because her priorities, perceptions, values, and beliefs will differ from your own, she will have to evaluate her own situation from her own perspective. Your solutions may not be right for her.

(9) Recognition of your own values

All of us have our own sets of values, feelings and thoughts about all aspects of life. The ways we were reared, our cultural and religious beliefs, and the experiences we have lived through have their effects on our value system. The era and locales in which we grew up also affect how we feel. Time and life experiences have a tendency to change some of our beliefs as we grow and mature. We may not always be aware of the values and beliefs we hold, but they are there just the same. It may be difficult for us to remember how we felt and acted during those important teenage years. We may have forgotten the intense feelings we had, the difficulties in making decisions, the great influences of our peers on our feelings, the rebellion we may have experienced toward our parents, and perhaps the difficulties we had in communicating with adults.

In working with pregnant adolescents, a most important aspect in a successful helping relationship is your ability to be clear on your feelings, beliefs, and values. If you aren't aware of your own personal biases, you are likely to


THE BEST THING FOR YOU IS...
WHEN I WAS YOUR AGE...
YAK - YAK
THE ONLY WAY TO GO ABOUT THIS...
OF COURSE, THE ONLY APPROACH IS...

unknowingly impose them upon the young women with whom you work. If you *are* aware of your values, you can make a conscious decision about the degree to which these values will affect your relationships with these young women.

You may have a deep-seated belief, for example, that teenagers should not be parents. If you are aware of this belief, you are in a position to choose how to deal with it. Even though you may not think teens should be parents, you can still choose to *support* the young person in her decision to become a parent. Once the teen has made the decision to parent, your role is to help her to become the best parent she can. If you can't support her in this choice or if you feel you will lay your biases on her in a negative manner, you are *not* the person to be working with her. The point is that you *consciously* guide your behavior. Conversely, if you remain unaware of your strong biases, they will influence your behavior and reactions in insidious ways.

(10) Be concerned, not emotionally involved

The distinction between concern and emotional involvement is vital to your own emotional health and may need to be learned. Persons who are new in the field of working with pregnant adolescents often are overwhelmed with all of the burdens that many young women face. When we first started working at New Futures School, we remember our feelings of wanting to "make the world right" for all of the girls and their babies. "If we could only take them home and give them the love and help they need" was a common feeling. There were many days when it was difficult to leave the worries and concerns at school. It can be an extreme emotional drain to self and family when you take your work problems home.

Becoming too involved with a young woman is not good for her either. There is an inherent danger that if her relationship with you is one of extreme dependency, she is less likely to develop her own coping skills. The goal is to develop a supportive relationship that helps the young woman move toward self-reliance and competence in managing her life situation.

The following quotations from our students lend further insight into what they look for in an effective helping person.

Being pregnant is scary — yet beautiful. Treat the pregnant girl as though pregnancy is beautiful and she'll bring on a better attitude towards her baby. Don't treat her like a problem or burden, treat her like a person whose life has changed and will keep on changing — but give her hope that she doesn't have to give up her dreams, that she can make more.

Pregnant teenagers aren't breakable. They need to be free enough to "breathe" and yet looked after enough to feel cared for. You can't stifle them because they still need to grow and learn for themselves before they become two. They need to be treated just like any normal teenager but with a little more consideration of their situation . . . *not babied!* The biggest problem for me was other people trying to tell me what was best for me, always forcing me to eat and treating me like an antique (never handle, too fragile).

The people here at New Futures are the best. The faculty are super. I feel that they give us girls a feeling of trust and independence. Being able to speak to the teachers, counselors, and nurses is a great help to the girls who have personal problems. It gives the girls a feeling of respect and warmth from them all. What I don't like to find in people is the questions asked about personal belongings or other personal subjects. I don't mind talking about these subjects, if I bring them up myself.

How Do You Answer Those Same Old Questions?

"You work with pregnant girls? That must be *very interesting!"* . . . "With birth control and all the sex education in the schools, you'd think today's kids wouldn't get in trouble." . . . "Isn't it awfully depressing?" . . . "What do you teach them, how (not) to get pregnant? Ha, ha!" . . . "Do you tell them to give up their babies?" . . . "Doesn't your kind of work *reward* that kind of behavior instead of discourage it?"

Anyone who works with pregnant teenagers has heard these and similar comments many times. They express the confusion and concern with which people view teenage pregnancy. Each of you who works with childbearing adolescents is a representative to the general public. Keep in mind that the person asking the questions is showing interest. With each new encounter, you have an opportunity to clarify their questions and perhaps to turn your listener's attitude in the direction of positive support. The outcome of such conversations will depend upon your own attitude and willingness to answer their questions.

How can a person feel liked
unless somebody likes him?

How can a person feel wanted
unless somebody wants him?

How can a person feel accepted
unless somebody accepts him?

How can a person feel he's a person
with dignity and integrity unless someone treats him so?

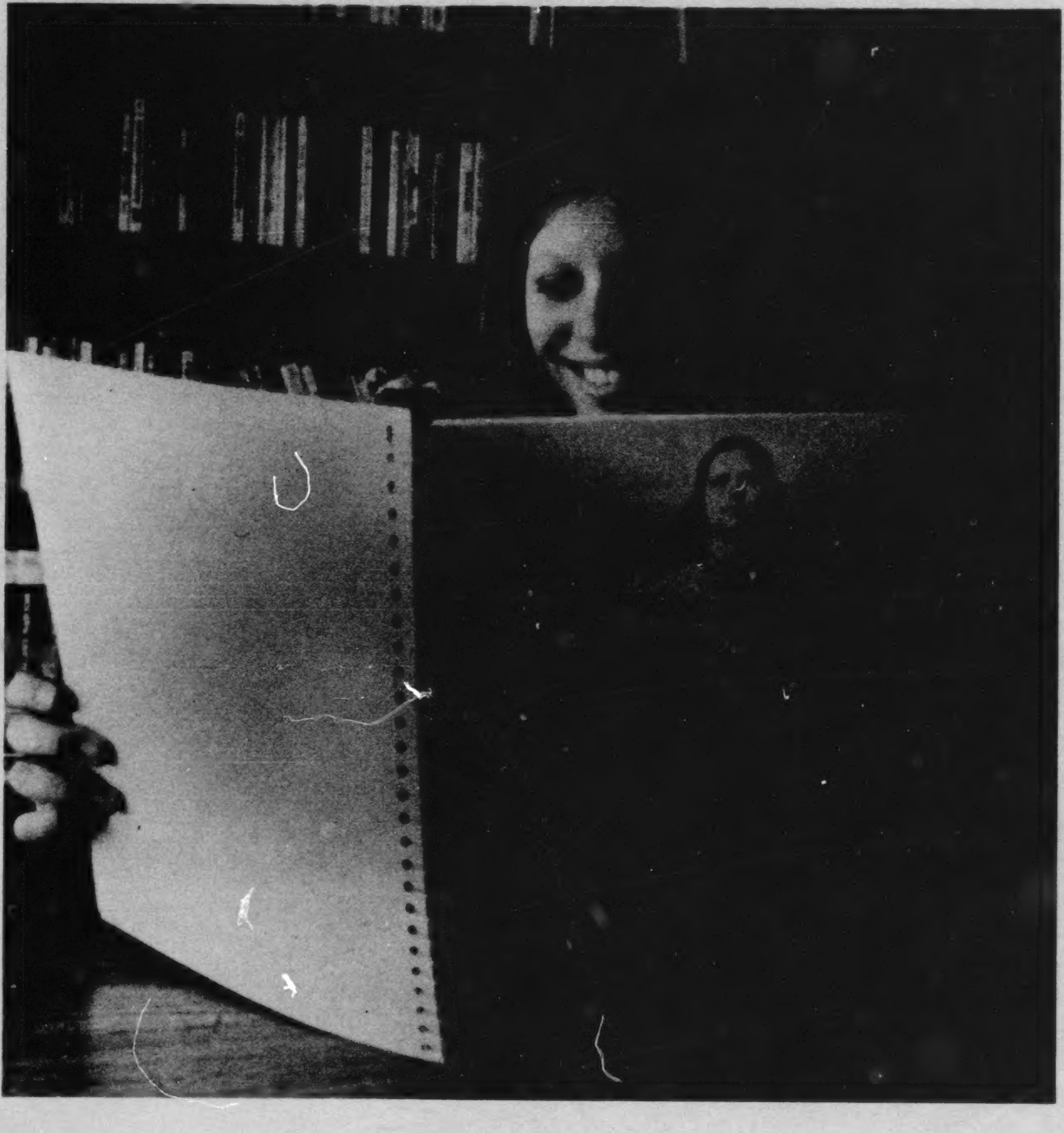
And how can a person feel that he's capable
unless he has some success?

— Arthur W. Combs

Part Five

GUIDE FOR USING

Teenage Pregnancy: A New Beginning



Guide For Using Teenage Pregnancy: A New Beginning

This section is a guide designed to assist in the use of *Teenage Pregnancy: A New Beginning*. For each of the chapters in the text, we have designed lesson plans to aid in both classroom and individualized teaching. The chapter lesson plan outlines are explained below:

Outline Headings:	**Explanation:**
Chapter number Title Page numbers	Specific information related to the student text
About the Chapter	Background information, including hints for teaching, possible pitfalls, additional content, and other pertinent details
I. Chapter Goals	Main objectives for the chapter
II. Important Concepts	Generalizations related to the chapter content
III. Learning Objectives	Specific behavioral outcomes for the learner
IV. Content Overview	Outline of the main topics and page references
V. Suggested Learning Activities	Classroom and individualized learning strategies
VI. Questions for Discussion/Study Guide	Questions designed to stimulate thinking and to reinforce learning
VII. Resource Materials: Films, filmstrips, slides, cassettes, charts, games, pamphlets, books and articles	Supplemental materials to enhance teaching and learning
VIII. Additional charts, illustrations, and handouts	Materials suitable for reproduction and distribution to students

Teenage Pregnancy: A New Beginning is currently being used in a variety of settings by helping persons with training in a number of fields. It has proven useful for both individualized study and classroom use. The way the text is used will depend upon the setting in which you work. We encourage you to be creative in adapting the text and supplemental activities appropriately for your use.

The length of time required to cover the content is variable. Some students, working in individualized study for credit, may complete the entire text and the study guide questions in as little as three weeks. In a series of small group meetings, it may be appropriate to deal with one or more chapters each time. In a classroom situation, as much as a week can be spent on expansion of the content in each chapter.

Suggested Learning Activities

In this section we have endeavored to include a variety of both teaching and learning strategies. Some are more appropriate for use in a group or class setting while others are geared more to the individual learner. Most of the activities are designed for students although in some cases it may be more appropriate for you to initiate the activity. It is not necessary that all of these actvities be used in teaching the content! We do suggest, however, that a variety of strategies be used whenever possible. Learning takes place through the various senses. For this reason it is highly effective to include verbal, auditory, visual, and tactile experiences to facilitate learning.

In several chapters we have suggested the use of guest speakers. These people can be valuable resources. We urge caution, however, in your selection of guests. Whenever possible, interview the speaker before the class presentation. It has been our unfortunate experience that some speakers do more harm than good. For example, the guest *must* be able to speak in language that teenagers understand! If the speaker uses terminology that is above the level of the students' understanding, the time will be wasted. On the other hand, avoid the speaker who considers teenagers to be children and speaks too simply.

In your interview you can also ascertain some of the resource person's values related to teenage pregnancy. If you sense strong biases or feel for any reason that this person's approach is inappropriate, it is best to look elsewhere. Be particularly careful when inviting guests to speak on sensitive or controversial topics such as birth control, breast feeding, drugs, childbirth approaches, etc. A closed-minded individual may be insensitive to other alternatives and viewpoints. A narrow approach can result in confusion, anger, and/or guilt in the students.

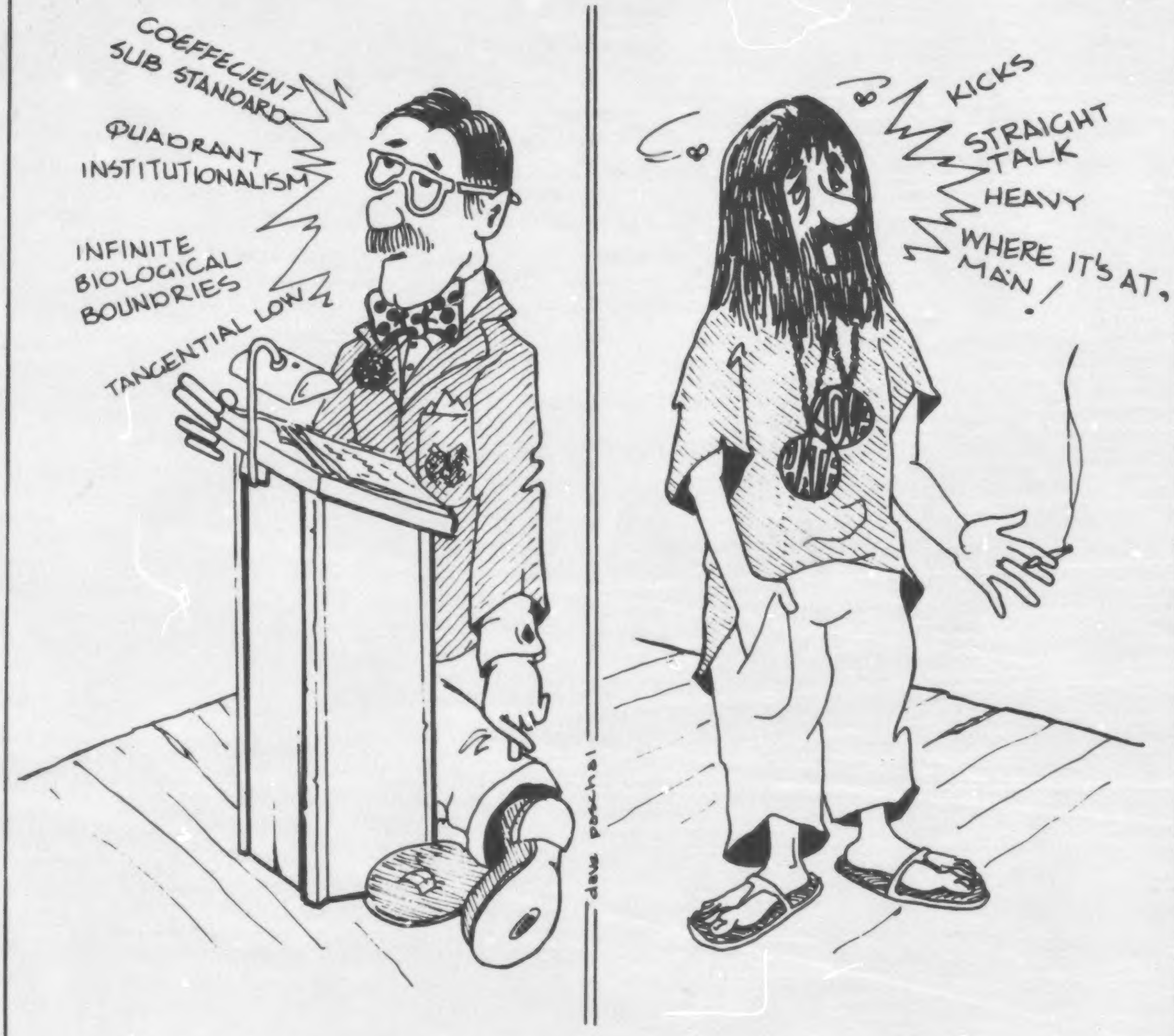
Questions For Discussion / Study Guide

These questions are designed to reinforce the learning of the chapter content. They follow closely the Learning Objectives for each chapter and may be utilized in a variety of ways. In the classroom the questions may be used as a basis for discussion. We have found them particularly valuable as written assignments. Having students complete these assignments helps to prepare them for class discussion. Since absenteeism is often a problem with pregnant students, these assignments are useful for make-up work. In individualized study they can be used as partial requirements for earning credit. The questions can also serve as a basis for quizzes or examinations.

Audio-Visual Materials

(Films, Filmstrips, Slides, Cassettes)

At the end of each set of lesson plans, we have included titles of films, filmstrips, slides, and other audio-visual aids that would be helpful in presenting the subject matter. Audio-visual materials serve a number of purposes and, if selected carefully, can greatly facilitate learning and provide supplemental instruction. The young women in our program have always enjoyed watching films and report that information is often easier to grasp and more meaningful when visually presented.


COEFFECIENT
SUB STANDARD
QUADRANT
INSTITUTIONALISM
INFINITE
BIOLOGICAL
BOUNDRIES
TANGENTIAL LOW
KICKS
STRAIGHT
TALK
HEAVY
WHERE IT'S AT,
MAN!
dave paschal

Select your speakers carefully to ensure that the approach and content is appropriate for your students.

Let us warn you, however, that teenagers can also be the greatest film critics. If the film appears to them to be outdated or to have a phony approach to the topic, they will react right away. They will tune out language that is too technical and will criticize "old-fashioned" clothes or hairstyles. It is also important to consider whether films are culturally relevant to your clientele. For these reasons we suggest that you preview audio-visual materials before deciding to use them.

Most of the films we have listed have been made within the past decade. We have also referenced some older films when we felt that the subject matter was particularly well presented and not outdated. We have intentionally left some films off the list that may appear on some widely distributed lists. Our choice of which films to include was largely subjective, based on our own experience and philosophy. There are many other films on the market which we have never seen, and new ones are continually coming out. Thank goodness, more and more of these are appropriate for use with teenage mothers. We suggest that you add your own favorites to our film list and that you make your own decisions about which films are appropriate for your area, clientele, and working situation.

In the Resource Materials section at the end of this book, the audio-visual aids are listed alphabetically by type (films, filmstrips, cassettes, etc.). We have also included other descriptive data. Whenever possible, the rental fees have been included. When we have known the current purchase price and when we have known that the price is particularly reasonable, that information has also been given. The average cost of 16 mm film is between $100 and $400. Filmstrips and slide/tape presentations often serve the purpose just as well and usually cost under $50. The majority of film companies will let you preview films at little or no cost by request and are happy to provide you with whatever additional information you may need. Since purchasing audio-visuals can be quite expensive, we suggest that you explore your local community agencies, hospitals, State Departments of Education, clinics, and March of Dimes chapters to find what may be available for loan. We have included a list of places to inquire about inexpensive and/or free materials as well.

One way to save money and to exercise your creativity is to design your own materials for classroom use. Often visual aids can be made from inexpensive and readily available materials. In addition to being less expensive, your homemade visual aids can be *exactly* tailor-made for your needs and for the interest level of your students. For years we made our own nutrition teaching aids with poster board, magazine pictures, and magic markers. By making our own we could stress what we felt was particularly important and include the foods indigenous to our own area.

You can also make audio-visuals with a camera and some cassette tapes. Several years ago, as an English project, our students made a slide/tape presentation entitled "I'm Not Bad, Just Pregnant." This presentation contains the students' own statements of their thoughts, feelings, and options related to their pregnancies. Making the film provided the opportunity for students to clarify their thinking, explore options, and share much of themselves. Many of their family members, husbands, and boyfriends also became involved. "I'm Not Bad, Just Pregnant" has been useful as a discussion starter on the topic of decision making in our own program. It has been extremely valuable and well received as a community awareness tool. Although not "professional," the presentation speaks from the heart; and its message comes across.

Printed Material

(Pamphlets, Books, Articles)

For each chapter we have listed written resources that provide supplemental information. Though some of the books and articles may be at reading levels too high for your students, these resources will prove valuable to you. In the chapters, these books and articles are listed by titles and authors. Complete bibliographical data has been provided in Part Seven, Resource Materials section, at the end of this book. Pamphlets are listed in this section by source; and most are available at little or no cost.

Additional Charts, Illustrations, and Handouts

With some chapters we have included extra illustrations and charts that are suitable for reproduction. These may be reproduced for use as handouts, study sheets, or transparencies. The charts and illustrations that have been approved for reproduction have the following statement at the bottom of the page: "Permission granted by New Futures, Inc., for reproduction of this material." *No other material in this book may be reproduced without written permission of New Futures, Inc.*

Part Six

LESSON PLANS FOR

Teenage Pregnancy: A New Beginning

General Goals and Objectives of Teenage Pregnancy: A New Beginning

To provide information to childbearing adolescents to help them do the following:

1. *Achieve greater emotional and mental stability with emphasis on the development of a positive self-concept;*
2. *Understand the anatomy and physiology of human reproduction as a basis for understanding conception, pregnancy, childbirth, and family planning;*
3. *Understand the process of fetal growth and development and the causes and prevention of birth defects;*
4. *Understand the physical and emotional aspects of the childbearing experience with emphasis on the normal and natural rather than the abnormal and exceptional;*
5. *Increase self-awareness and understand the problem-solving process as a basis for sound decision making;*
6. *Understand the characteristics and needs of the infant and develop skills for meeting these needs;*
7. *Understand the responsibilities of parenthood and develop confidence in the parenting role;*
8. *Increase awareness and understanding of family planning and birth control methods in relation to the individual, the family, and society as a whole.*

Chapter One

"TEENAGERS TALK ABOUT THEIR PREGNANCIES"

Pages 5-7

About the Chapter

The purpose of this initial chapter is to present an overview of teenagers' reactions to their pregnancies and to help them get in touch with their own feelings. Most of the content consists of quotations from New Futures School students with very little input from the authors. Many teenagers feel alone and isolated when they first discover they are pregnant, and they report that it is reassuring to realize that there are others who share their feelings.

Those of us who work with these young women need to be aware of the difficult position of the teenager in our society. They are neither children nor adults and often have had very little experience in decision making. The advent of a pregnancy and the accompanying decisions and changes may be overwhelming for these young women. They need assistance with sorting out their feelings and thoughts, which may be quite confused or conflicting.

It is important for the people who work with pregnant teens to be accepting and to offer them reassurance that they can deal with the situation effectively. Begin as early as possible to help the young woman build a belief in herself by helping her discover and capitalize on her strengths. Even though she may appear to be quite young or immature, don't lose sight of her potential competency. Gradually you can begin to introduce the concept that she does have choices regarding her reactions to and regarding the outcome of this pregnancy.

At times the pregnant girl feels bombarded with advice, much of it conflicting. Her family and friends may all be telling her what decisions she should make. You can be of most assistance by helping her explore her alternatives and by offering to support her in carrying through her decisions. Beware of being an advice giver yourself! It may be difficult for you to avoid telling her what to do. Remember, you are *not* the one who will be living with these decisions. It is your role to facilitate the maturation process by assisting the young woman to take responsibility for her life. (The decision-making process is discussed further in connection with Chapter 8. "Making Decisions For You And Your Baby." This chapter can be found on page 83 of this guide.)

The issue of body image is an important one. The teenage years are usually the time when a young woman is working on establishing a sound sense of self-identity. This sense of self-identity may be closely linked to her physical appearance. During the time when looking like one's peers is of foremost concern, an ever-enlarging abdomen can be difficult to accept.

Our students tell us that adults often look at their bellies when they speak to them, rather than looking into their eyes. We know of one male teacher who was so insensitive as to scoff at a student's protruding navel. It is essential that we don't lose our sensitivity to what changing body image can mean to a young woman. Your acceptance and respect for a young mother may be major factors in how she reacts to pregnancy and in how she views herself.

When we were new teachers, we were sometimes offended when students seemed disinterested in what we considered super class presentations. It took us a while to realize that students' reactions in class were not personally directed at us. Mood swings are very real! If a young woman is worrying about where she is going to live or is daydreaming about her forthcoming marriage, she may find it difficult to concentrate in class. Depending on her stage of pregnancy, the young woman's interest level and ability to focus on instructions and educational materials may vary. Early in pregnancy, she is adjusting to the idea that she is pregnant. She may be coping with unfavorable parental and boyfriend reactions as well as with disappointment in herself. It may be very difficult for her to be alert and attentive to your discussions when her biggest concern is whether she'll ever see her boyfriend again or where she will sleep tonight!

If your student is in the middle trimester of pregnancy, you will probably notice she is more outgoing and eager to learn. She may have periods of daydreaming, however, when she appears to be in another world. Fantasizing about her unborn child is a necessary stage in the maternal process.

As the young woman nears delivery, she may become increasingly uncomfortable physically and preoccupied with approaching labor. If she isn't sleeping well at night, she may well sleep through your class! Be flexible and understanding. Even if her performance in class doesn't live up to your expectations, she may be getting some of her needs met just by being there.

I. Chapter Goals

A. To present an overview of teenagers' reactions to their pregnancies

B. To encourage personal exploration of thoughts and feelings related to pregnancy

C. To help the young mother express and cope with her concerns about pregnancy

D. To introduce the concept of decision making, emphasizing that a young woman can make choices for her life

II. Important Concepts

A. The normal hormonal and psychological changes of pregnancy may cause emotional instability in the mother.

B. The reactions of the adolescent to her pregnancy may vary from denial and hostility to acceptance and happiness.

C. Exploring thoughts and feelings related to pregnancy with other pregnant adolescents helps overcome feelings of loneliness and fear.

D. Taking an active role in one's own decision making is an integral part of the maturational process.

E. Acceptance and support, rather than advice giving, can positively affect the young woman's sense of self-worth.

III. Learning Objectives

Due to the nature of the content, there are no stated behavioral objectives for this chapter. However, be alert to the possibility that the student may need assistance with a variety of concerns; and be ready to offer support and/or appropriate referral.

IV. Content Overview

	Text page
A. Reactions to pregnancy	5
B. Moods	5
C. Body image	6
D. Decisions	6
E. Advice givers	7
F. Personal choice	7

V. Suggested Learning Activities

A. View slide presentation made by New Futures School students.

B. Keep a diary of thoughts, feelings, questions, needs, etc.

C. Make a collage using magazine pictures to express feelings about one's own body.

D. Write or discuss in teams of two what part of the student's appearance she (a) least likes, (b) most likes, and (c) would change if she could.

E. Fill in chart called "What People Want Me to Be Like" from part VI below. Discuss the problems caused by people's different expectations.

F. Respond to the following questions individually, in class, or in small groups.

When I need help, where do I go
...for school problems?
...for personal problems?
...for friend problems?
...for family problems?

Encourage students to share the wide range of help available, and list sources on the blackboard.

G. Invite a counselor, minister, and/or other helping persons to discuss the value of seeking help with problems.

H. Talk for one full minute to a partner about all of one's *good* qualities while partner listens attentively. Switch. Students may think this exercise is embarassing, but it is good for their self-esteem. You may want to list areas of their lives in which they normally put themselves down: physical, mental, familial, sexual, social, etc.

I. Discuss or answer in writing the questions in part VI.

VI. Questions for Discussion/Study Guide

A. Finish each sentence by writing your own ideas and feelings.
1. "When I first found out I was pregnant, I...."
2. "Now that I'm pregnant, I feel...."
3. "The hardest decision I've had to make about pregnancy is...."
4. "When people give me advice, I...."
5. "When I look at my body, I see...."
6. "I am worried about...."

B. Fill in the following chart with your ideas about what other people want from you.

"What People Want Me to Be Like"

PARENTS	BROTHERS/SISTERS	FRIENDS
NEIGHBORS	**TEACHERS**	**ME**

Underline all the things you agree with on the above chart. Cross off those things you don't agree with.

VII. Resource Materials

A. Film: *Woman-Child*

B. Slide/tape: "I'm Not Bad, Just Pregnant"

C. Pamphlets and Bulletins:
1. *Adolescent Pregnancy and Childbearing — Growing Concerns for Americans*, Population Bulletin
2. *Days of Change*, March of Dimes PEP
3. *Inside Your Body, Inside Your Head*, March of Dimes PEP
4. *School-Age Parenthood*, Nye

D. Books:
1. *Coping With School Age Motherhood*, Walsworth and Bradley
2. *Mr. and Mrs. Bojo Jones*, Head
3. *Only Human — Teenage Pregnancy and Parenthood*, Howard
4. *Pregnant Too Soon: Adoption Is an Option*, Lindsay
5. *Teenage Parents*, Edwards
6. *The Teenage Pregnant Girl*, Zackler and Brandstadt

E. Articles:
1. "Pregnancy in Adolescents: Scope of the Problem," Stickle and Ma
2. "The Social Consequences of Teenage Parenthood," Furstenberg

Chapter Two

"UNDERSTANDING HUMAN REPRODUCTION"

Pages 8-12

About the Chapter

It has been our experience that teenagers often have a very limited understanding of reproductive anatomy and physiology. A common pitfall is to assume that when a teenager is pregnant, she is knowledgeable in this area. This assumption is usually *not* correct. For the most part, we have found that initially our students have been neither knowledgeable nor comfortable with the subject. However, the basic information presented is essential for the understanding of the maternity cycle and contraception. You will find young women eager to learn this information, but they need your assistance and encouragement.

In the student text we used full-length drawings of the female and male anatomies. Very often young people have a distorted idea of the size and location of their reproductive organs. For example, two common misconceptions are that the uterus fills the abdomen and that the ovaries are the size of oranges. In your discussions it is important to emphasize size and location. At the end of this section, we have included charts of the female and male reproductive systems that may be used for duplication or transparencies.

You will also notice that following the anatomical terms, we have put the slang or more common words in parentheses. If teenage women are familiar with any terms at all, it is usually with these common ones. The slang we have included is most often used in New Mexico. It is important for you to find out what language the teenagers in your area use. We feel that your communication with young women will be clearer if you are able to use the language they understand. Gradually you can begin to introduce more technical terminology. There may also be cultural barriers to the discussion of anatomy and/or sexuality.

Don't be discouraged if you don't have an open, enthusiastic discussion at the beginning. In a classroom setting students often have a fear of making an incorrect or inappropriate response. For this reason some of the suggested learning activities allow the students to respond anonymously.

We have found that menstruation is not an easy topic to teach. Often young women assume they understand menstruation because they saw a Disney film in fifth grade. Many don't seem to consider the topic important because it is not happening to them at the moment. You can stress that the understanding of menstruation will help them understand the reproductive cycle. It is also important for them to be knowledgeable about their body functioning so they can maintain optimum health. In your discussions you may find that few teenage women even remember when their last menses began. Once they understand why this information is useful, they tend to become much more conscious of their body functions.

The time of ovulation is another difficult concept to teach. Most young women assume that they ovulate halfway through their cycles. While this assumption is usually true of a regular twenty-eight day cycle, it is not true if the cycle is longer, shorter, or irregular. The understanding of the concept that ovulation usually occurs *fourteen days before the period begins*, is essential to the understanding of conception and/or contraception.

The teenage girl knows even less about male anatomy and physiology! Frequently she does not know what the male organs look like, let alone how they function. Her knowledge may be limited even though she is married or has a steady boyfriend.

In the classroom the usual response to a discussion of male anatomy is silence with intermittent giggling, an indication of embarrassment, not lack of interest. Chances are that the young women are listening intently and are sincerely interested in learning more about the subject. Again they may have a fear of appearing either too knowledgeable or too naive in front of their peers. The more at ease and accepting you are, the easier it will be for them to ask you questions and participate in the discussion.

The study of human sexuality encompasses far more than the information included in this chapter. You may wish to further pursue the study of human sexuality either at this point or after you have completed the study of pregnancy and childbirth. We have included resource materials on sexuality at the end of this section in the event you plan to do more in-depth study. Of course, the amount of time and depth of study will depend upon the setting in which you are working and upon your own levels of expertise and comfort.

When dealing with the topic of sexuality, you will want to be prepared for students' questions. In addition to outside study, we strongly urge that you examine your own personal values and standards. You can expect to be asked some very personal questions. Teenagers are quite sensitive to body language, tone of voice, and general affect accompanying your responses. Often your behavior will communicate more loudly than your words. *If you make the decision to tell your students what your own values are, make it clear that these are your own beliefs and not statements of universal fact.*

If you are uncomfortable discussing sexual matters, it may be more appropriate for you to refer questions to a trained person or to invite a speaker to your class. Also, if you are aware that you are strongly opposed to teenagers being sexually active, you are probably not the best person to be discussing this topic with them.

The main focus of the text's brief discussion of sexual feelings is on the importance of making choices that are consistent with one's own values and beliefs. The emphasis is on taking responsibility for the consequences of those choices. Discussions related to sexual activity may elicit feelings of guilt in some young women. Discourage self-depreciation and dwelling in the past. Encourage them to examine their own values and to focus on sexual decision making now and in the future.

I. Chapter Goals
  A. To provide information about the anatomy and physiology of the female reproductive system
  B. To provide information about the male reproductive system
  C. To encourage and guide personal exploration of values related to the handling of sexual feelings

II. Important Concepts
  A. Knowledge of normal reproductive anatomy and physiology can favorably influence the reproductive experience.
  B. Information about the reproductive system contributes to a positive body image and fosters responsible health care.
  C. The individual's own value system will determine to a large extent the manner in which sexual feelings are handled.

III. Learning Objectives

The student will be able to do the following:
  A. Draw a picture and label each part of the female reproductive organs;
  B. Identify and explain the function of the ovaries, Fallopian tubes, cervix, vagina, uterus, and ovum;
  C. Explain what menstruation is;
  D. Explain what ovulation is and when it occurs;
  E. Define fertilization;
  F. Define nocturnal emission and erection;
  G. Identify and explain the function of the penis, testicles, scrotum, vas deferens, seminal vesicles, urethra, bladder, and sperm;
  H. Explain the male's role in human reproduction;
  I. Be able to discuss the question "Do you believe teenagers who are not married should have sex?"

IV. Content Overview

Text Page

A. Female anatomy 8
  1. Ovary
  2. Fallopian tube
  3. Uterus
  4. Cervix
  5. Vagina
  6. Ovum

B. Female reproductive cycle 9
  1. Ovulation
  2. Menstruation
  3. Fertilization

C. Male anatomy 10
  1. Penis
  2. Testicles
  3. Scrotum
  4. Vas deferens
  5. Seminal vesicles
  6. Urethra
  7. Bladder
  8. Sperm

D. Male sexual functioning 10
  1. Secondary sex characteristics
  2. Nocturnal emission

   3. Erection
   4. Ejaculation
   5. Semen
- E. Human sexuality 11,12
   1. Sexual intercourse
   2. Sexual feelings

V. Suggested Learning Activities

- A. Make a sketch of the female reproductive system *before* studying the manual. Repeat *after* study to compare the differences. This activity may also be done for the male reproductive system.
- B. View films and/or filmstrips on reproductive physiology.
- C. Respond verbally or in writing to this question to Dear Abby:
  "Dear Abby: My mother says it's wrong to have sex before marriage. My friends are doing it, and my boyfriend wants to. What should I do?"
- D. Invite a qualified speaker (counselor, family planning specialist, etc.) to discuss human sexuality.
- E. Discuss or answer in writing the questions in part VI.

VI. Questions for Discussion/Study Guide

- A. Draw a picture of the woman's reproductive organs and label each part.
- B. Explain the function of each of the following:
   1. Ovary
   2. Fallopian tube
   3. Uterus
   4. Cervix
   5. Vagina
   6. Ovum
- C. Explain what menstruation is.
- D. How old were you when you started menstruating? How did you feel about it?
- E. What is ovulation?
- F. When do you ovulate?
- G. What is fertilization?
- H. During what time of the month can a woman get pregnant?
- I. Draw a picture of the man's reproductive organs and label each part.
- J. Explain the function of each of the following:
   1. Penis
   2. Testicles
   3. Scrotum
   4. Vas deferens
   5. Seminal vesicles
   6. Urethra
   7. Bladder
   8. Sperm
   9. Semen
- K. What is nocturnal emission? Is this normal?
- L. What is an erection? What causes an erection?
- M. How many sperm are ejaculated each time a man "comes"?
- N. How many sperm does it take to fertilize an egg?
- O. How would you answer this letter?
  "Dear Abby: My mother says it's wrong to have sex before marriage. Some of my friends are doing it, and my boyfriend wants to. What should I do?"

VII. Resource Materials

- A. Films on human anatomy and reproduction:
   1. *Boy to Man*
   2. *Girl to Woman*
   3. *Human Growth III*
   4. *Human Reproduction*
   5. *Linda's Film on Menstruation*
   6. *The Miracle of Life*
   7. *Then One Year* (combines 1 and 2)
- B. Films on sexuality and sexual feelings:
   1. *About Sex*
   2. *How About You?*
   3. *Teen Sexuality: What's Right for You?*
- C. Slides: "Birth Atlas" Slide Series, Maternity Center Association
- D. Charts:
   1. "Birth Atlas," Maternity Center Association
   2. "Female Pelvis," Maternity Center Association
   3. "The Male and Female Complete Body Charts," Spenco
   4. "Organs of Human Reproduction," Maternity Center Association
- E. Books:
   1. *Fundamentals of Human Sexuality*, Katchadourian
   2. *Inside Mom*, Caveney
   3. *Our Bodies, Ourselves*, Boston Women's Health Book Collective
   4. *Reproduction, Sex, and Preparation for Marriage*, Crawley, *et. al.*
   5. *The Sexual Adolescent,* Gordon
   6. *Understanding Human Sexuality*, Cohn
- F. Article: "Ten Reasons Why 'Sex Talks' With Adolescents Go Wrong," Jensen and Robbins

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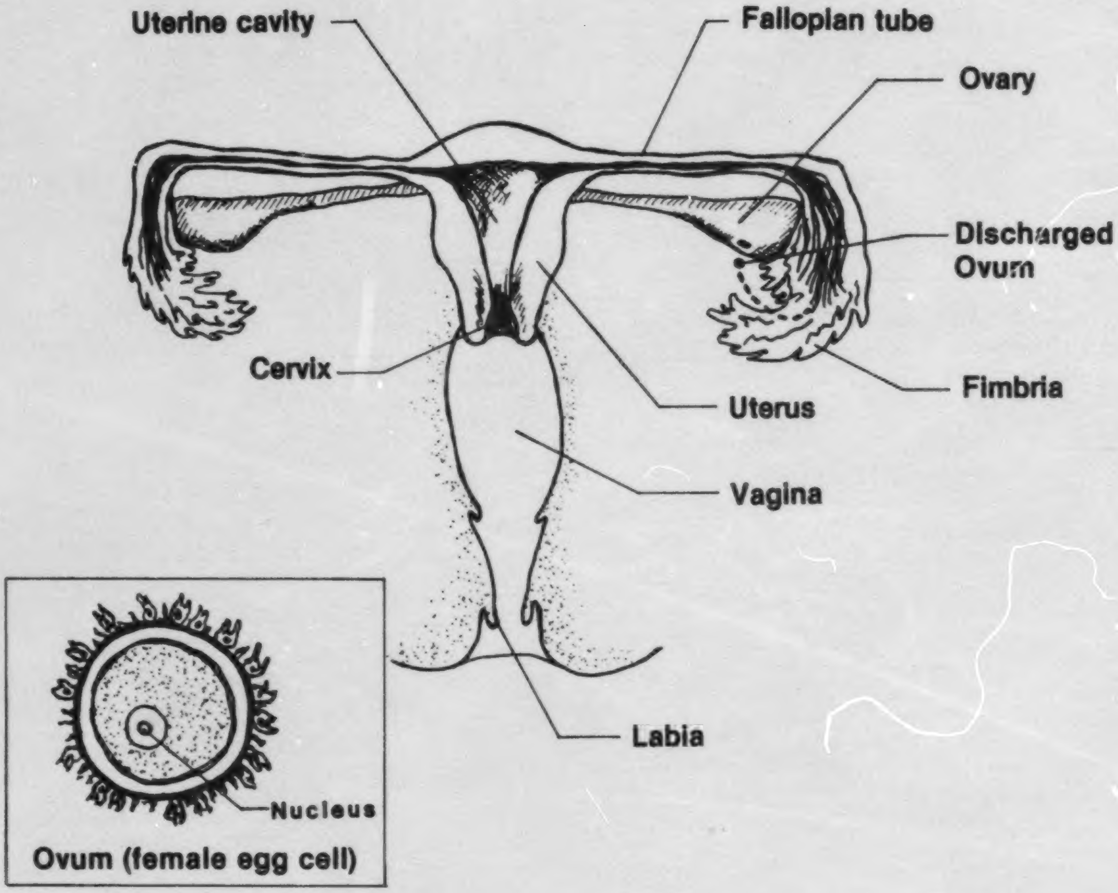
Uterine cavity
Fallopian tube
Ovary
Discharged Ovum
Cervix
Fimbria
Uterus
Vagina
Labia
Nucleus

Ovum (female egg cell)

The Female Reproductive System

(Front View)

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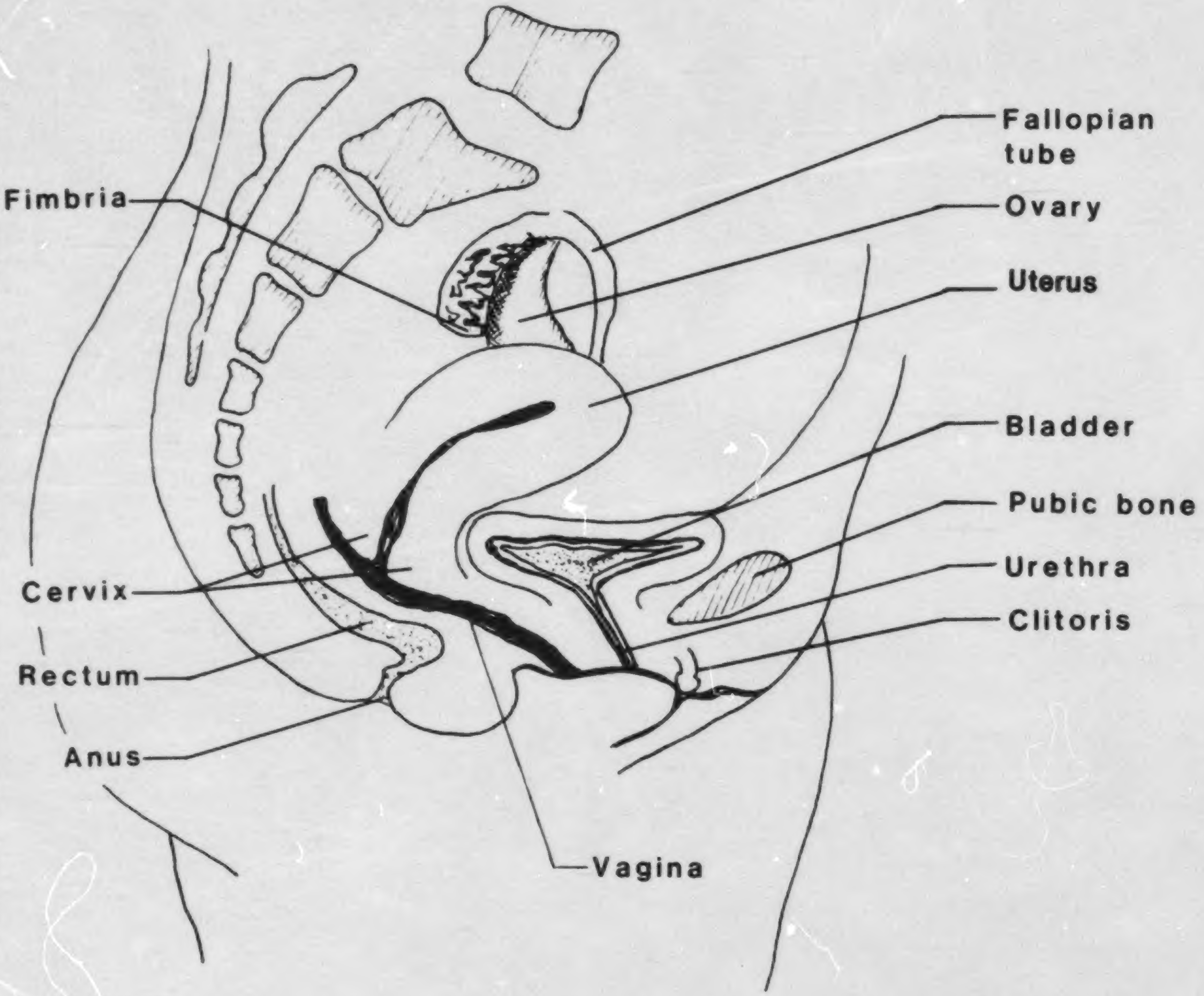
Fimbria
Fallopian tube
Ovary
Uterus
Bladder
Pubic bone
Urethra
Clitoris
Cervix
Rectum
Anus
Vagina

The Female Reproductive System
(Side View)

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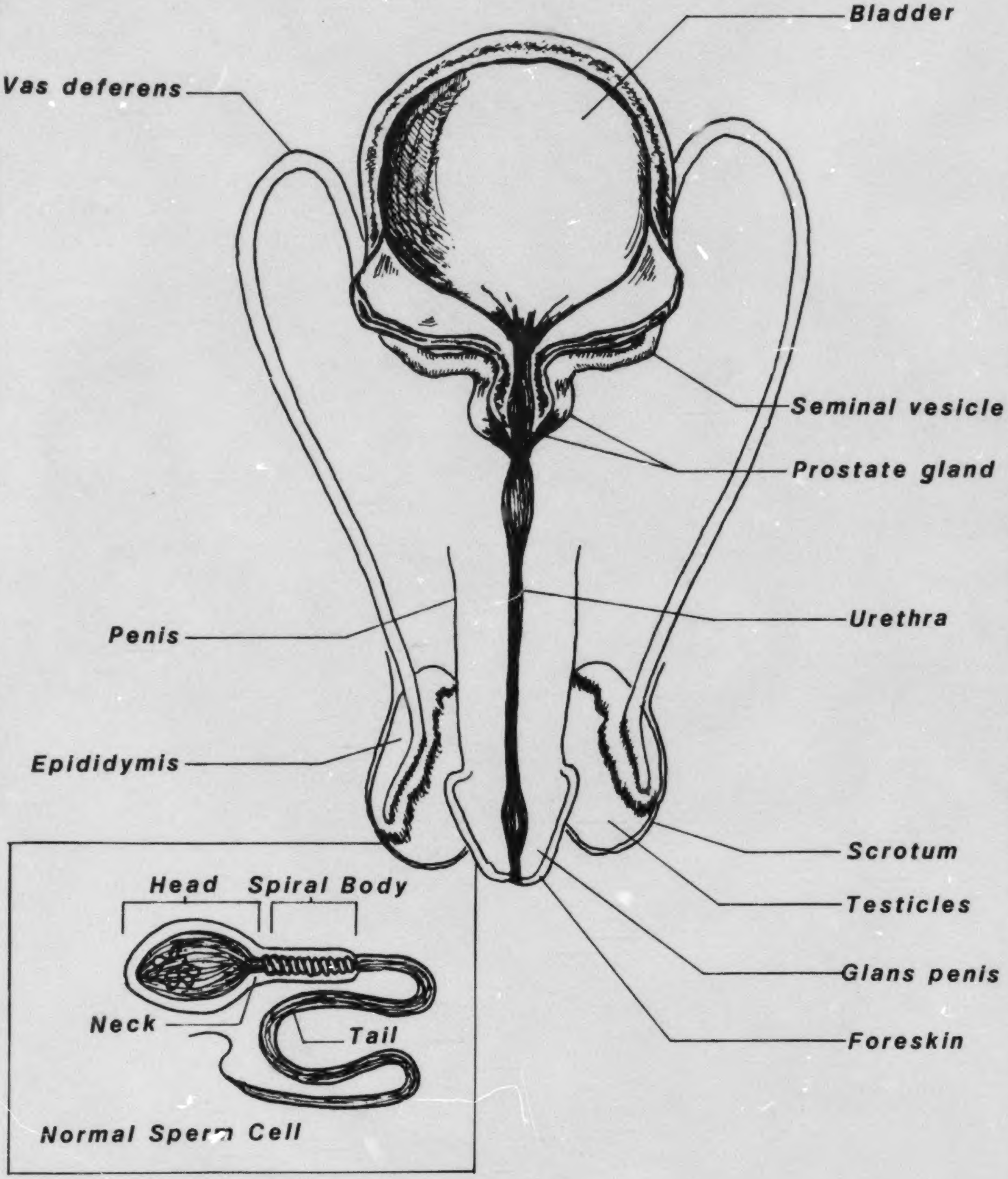
Bladder
Vas deferens
Seminal vesicle
Prostate gland
Urethra
Penis
Epididymis
Scrotum
Testicles
Glans penis
Foreskin
Head
Spiral Body
Neck
Tail
Normal Sperm Cell

The Male Reproductive System
(Front View)

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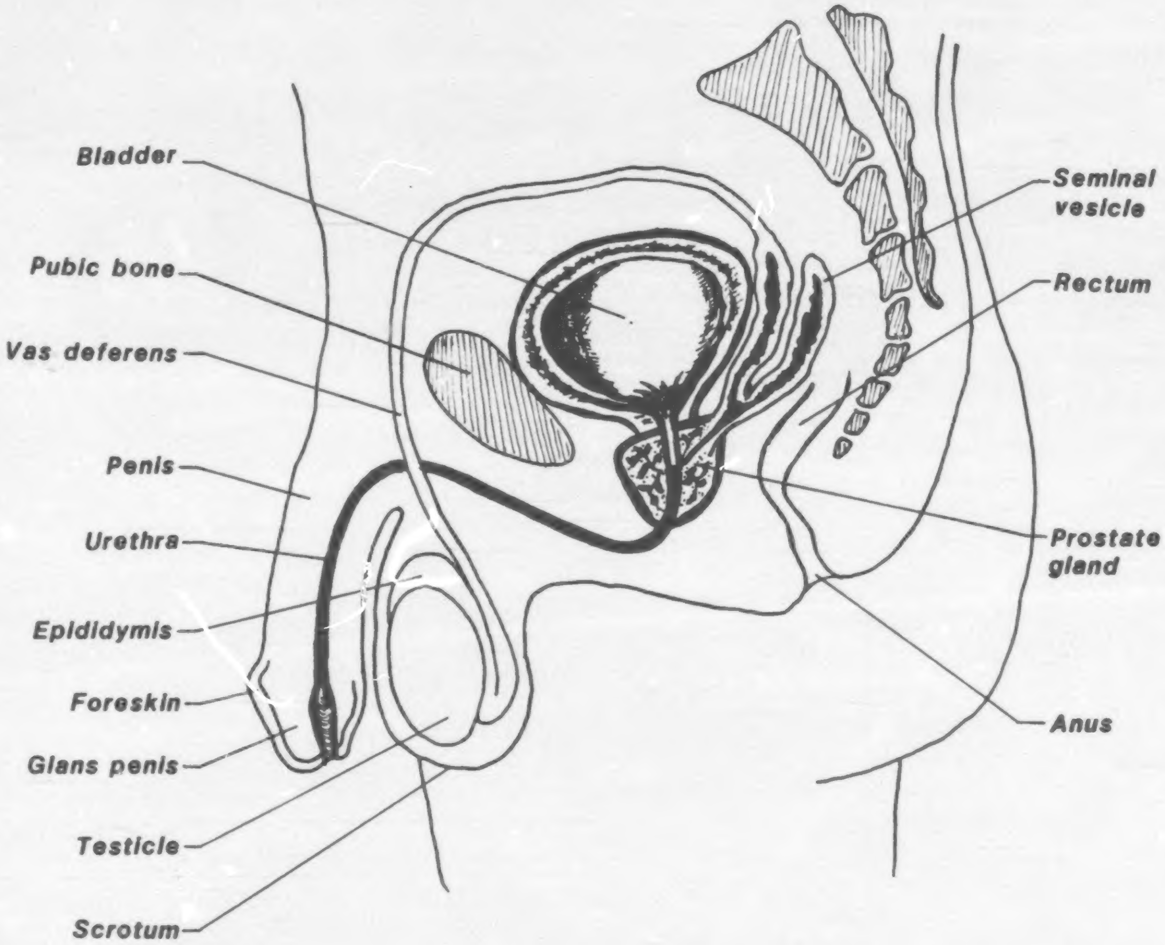
Bladder
Pubic bone
Vas deferens
Penis
Urethra
Epididymis
Foreskin
Glans penis
Testicle
Scrotum
Seminal vesicle
Rectum
Prostate gland
Anus

The Male Reproductive System

(Side View)

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Chapter Three
"TWO STORIES AT ONCE"
Pages 13-20

About the Chapter

The study of fetal development is usually very popular with young mothers. One student put it this way: "I spent at least two hours reading and re-reading Chapter 3. It really had me going! I was amazed at how fast babies really grow. It surprised me to learn that babies are fully developed by the end of the third month!"

The fascination with fetal development may be accompanied by some concern when teenage mothers realize the significance of the first three months. Often they were not aware of the fact they were pregnant or were unwilling to admit it. For these or other reasons, teenage mothers may not have had any prenatal care during the first trimester. It is also likely that during this time their lifestyles included poor health habits. When discussing fetal development during the first trimester, young women may need reassurance. This issue is tricky. During that time their health habits *may* have endangered the developing baby. At the same time, it does no good for them to worry about it for the rest of the pregnancy. Provide them with the opportunity to discuss their concerns with you individually. You can be reassuring if the source of the worry is minor. If, however, the young woman had many abdominal x-rays during that time or used a lot of potentially damaging drugs, you should encourage her to discuss these problems with her doctor or nurse. The chances are that she will give birth to a normal child if she continues with good health practices during the rest of her pregnancy.

We have found that the comprehension of fetal development is facilitated by the use of visual resources. At the end of this chapter, we have listed several good films showing the actual development of the fetus from conception to birth. Charts and diagrams are also useful to facilitate the comprehension of the complex nature of fetal development.

Since teenage pregnancies are seldom consciously planned, the young woman may initially perceive her pregnancy as a *condition* that has happened to her. The study of fetal development may facilitate the transfer from the "I'm pregnant" state to one of "There's a life growing within me now." Once this transition is made, it is more likely that the mother will begin to take responsibility for the outcome of the pregnancy.

This chapter includes both fetal development and changes in the mother's body during pregnancy. By integrating the story of the baby with that of the mother, the student is helped to grasp the concept that the baby is a part of her body, having an effect on it. The young mother also begins to understand how her body accommodates the growth of the fetus. (For a more complete discussion of the common complaints related to physical changes, see Chapter 5, "Keeping Yourself Well During Pregnancy.")

How the young woman views the changes in her body during pregnancy influences the way she feels about herself. If the changes are perceived as positive, her self-esteem is increased. If she experiences the movements of the unborn child as pleasurable, she has already begun to relate to her child in a positive manner. If, however, the bodily changes and the fetus are viewed as a nuisance or with great displeasure, she may have more difficulty in establishing a healthy relationship with her child after birth. Whenever possible, accentuate the positives of your discussions without discounting her concerns.

Cultural Considerations

In this chapter we have included four captions describing childbearing customs and beliefs common to the Southwestern United States. Originally it had been our intention to include far more of this type of information. Our teaching experiences in a four-culture state taught us that the sharing of cultural customs and mores was interesting to our students and tended to

promote an atmosphere of mutual acceptance in our program. When we began actually to research the topic of childbearing and childrearing in the Southwest, however, we found innumerable variations of some customs and blatant disagreement as to the exact nature of others. There was so much variation, in fact, that we were able to include only these few.

We still believe that the concept is a good one, though, and we strongly encourage you to learn all you can about the heritage and customs of those with whom you are working. There are several reasons for being culturally aware. First of all, what you are teaching may be in direct conflict with what is being taught in the home! When such a conflict occurs, the young woman may feel quite confused and guilty. Even if she is motivated to do everything possible to take proper care of herself and her child, she may not be sure what to do. Our suggestion is that whenever possible you encourage tradition and discourage *only* those things which are known to be medically harmful.

Among many of our Spanish-speaking families, for example, there is a tradition of wearing a key on a string around the abdomen. The purpose of this tradition is to prevent birth defects. If this custom does not happen to be *yours*, you may unknowingly refute it! However, if the young mother believes the wearing of the key to be necessary and discontinues the practice, she will not feel that she is doing all she can to have a healthy baby. In this case we see no reason for discouraging a tradition.

The issue of cultural traditions is a subject of controversy in our nation today. It can be a particularly difficult issue for a teenage mother and her family. We believe that when working with these young women it is our responsibility to offer support in resolving these conflicts. To accomplish this goal, it is important to learn all you can about how pregnancy, childbirth, postpartum, *and* early parenthood are viewed by the people with whom you work. It is especially important to learn the traditions that are believed to promote a positive outcome for mother and baby, as well as to learn the taboos that are aimed at avoiding negative outcomes.

I. Chapter Goals

A. To discuss fetal development from conception to birth, emphasizing the importance of the first trimester
B. To explain the physiological and emotional changes occurring in the mother's body from conception to birth

II. Important Concepts

A. The first twelve weeks of pregnancy are the most critical time in the development of the fetus.
B. The baby grows more rapidly during the prenatal period than at any other time in his life.
C. Understanding normal physiological and emotional changes helps the mother adapt to the experience of pregnancy.

III. Learning Objectives

The student will be able to do the following:

A. Explain why the first 12 weeks of pregnancy are so important in the baby's development;
B. Explain what the placenta is and describe its function;
C. Explain the purpose of the bag of water;
D. Describe the baby's development at the third, fourth, sixth, seventh, and ninth months;
E. List five physiological changes expected in the mother during pregnancy;
F. List three emotional changes that may occur in the mother during pregnancy;
G. Define *implantation, embryo, umbilical cord, amniotic sac, amniotic fluid, colostrum, quickening, lanugo, vernix, engagement.*

IV. Content Overview

Text Page

A. Fetal development, the first three months....................... 13-14
  1. Fertilization
  2. Implantation
  3. Cell division
  4. Embryo
  5. Fetus
B. Fetal development, the fourth through ninth months.......... 16, 17, 19
  1. Quickening
  2. Skin protection: lanugo and vernix
  3. Activity and abilities of fetus
    a. Swallowing and hiccoughing
    b. Thumb-sucking
    c. Breathing movements
    d. Development of senses
    e. Somersaults and movements
C. Placental support system.......... 14, 17
  1. Description and function
  2. Umbilical cord
  3. Amniotic sac and fluid (bag of water)
  4. Mucus plug
D. Physical changes in mother...15, 16, 18, 20
  1. Amenorrhea (menstruation ceases)

    2. Breasts
    3. Nausea and vomiting
    4. Fatigue
    5. Urinary frequency
    6. Uterus
    7. Respiration
    8. Braxton-Hicks contractions (painless "warm-up" contractions)
    9. Posture ("waddling")
    10. Engagement ("dropping," "lightening")
  E. Emotional adjustments of mother.................. 15, 16, 18, 20
    1. First trimester
    2. Second trimester
    3. Third trimester
  F. Beliefs and customs........ 15, 16, 18, 20

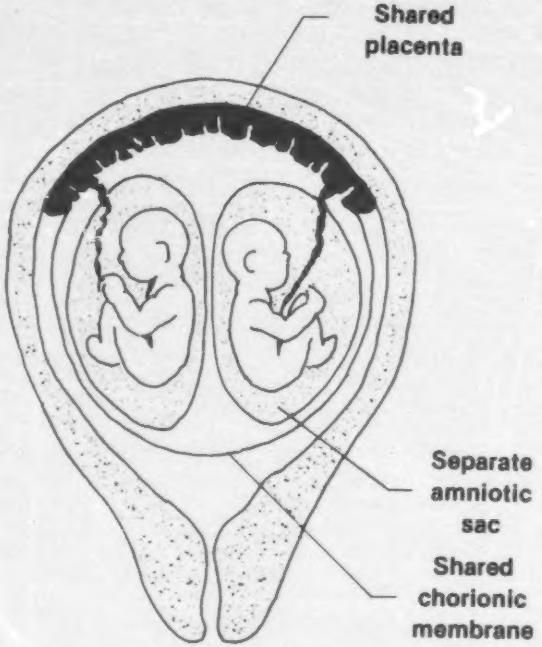
V. Suggested Learning Activities
  A. View a film and/or filmstrip on normal fetal development.
  B. Read and report on the stage of development of her own baby.
  C. Listen to a cassette of sounds inside the womb.
  D. Imagine what it is like to be a developing fetus: write, draw, or discuss from the fetus' point of view.
  E. Draw pictures of the fetus at various stages of development.
  F. Role-play unborn babies at various stages of development, comparing how they feel, what they look like, and what they can do.
  G. Draw maternal growth of uterus, breasts, etc.
  H. View film on the emotions of pregnancy.
  I. Role-play the mood swings of pregnancy (reactions to parents, boyfriends, doctors, etc.).
  J. Discuss or answer in writing the questions in part VI.

VI. Questions for Discussion/Study Guide
  A. Why are the first three months of pregnancy so important to the developing baby?
  B. What is the placenta? What does it do?
  C. What does the bag of water do for the unborn baby?
  D. Describe what the unborn baby looks like and what he can do at
    1. Three months (12 weeks)
    2. Four months
    3. Six months
    4. Seven months
    5. Nine months
  E. What do you think your baby looks like right now?
  F. There are many signs that may appear when you are *first* pregnant. List as many of these as you can.
  G. Which sign(s) did *you* notice first in your own body?
  H. What are the changes in the mother's body during each trimester?
    1. First trimester
    2. Second trimester
    3. Third trimester
  I. Which changes have been the hardest for you to handle? Which have been the easiest?
  J. How do the pregnant woman's emotions change during each trimester?
    1. First trimester
    2. Second trimester
    3. Third trimester
  K. How have your own moods changed since you became pregnant?
  L. Define the following:
    1. Fertilization
    2. Implantation
    3. Embryo
    4. Fetus
    5. Umbilical cord
    6. Placenta
    7. Amniotic sac
    8. Amniotic fluid
    9. Colostrum
    10. Quickening
    11. Lanugo
    12. Vernix
    13. Engagement

VII. Resource Materials
  A. Films:
    1. *Biography of the Unborn*
    2. *Emotional Aspects of Pregnancy*
    3. *The Miracle of Life*
    4. *When Life Begins*
  B. Filmstrips:
    1. *Life Before Birth*, Part I
    2. *Life Before Birth*, Part II
  C. Cassette/Record: "Lullaby From the Womb"
  D. Charts, games:
    1. "Birth Atlas," Maternity Center Association
    2. "Developmental Time-Line Chart," March of Dimes PEP
    3. "The Pregnancy Game"
  E. Pamphlets:
    1. *Inside Your Body, Inside Your Head*, March of Dimes PEP
    2. *Your Pregnancy*, Ortho
  F. Books:
    1. *A Baby Is Born*, Maternity Center Association
    2. *A Child Is Born*, Nilsson, et al.
    3. *From Conception to Birth*, Rugh and Shettles
    4. *Inside Mom*, Caveney
    5. *The Secret World of the Baby*, Day

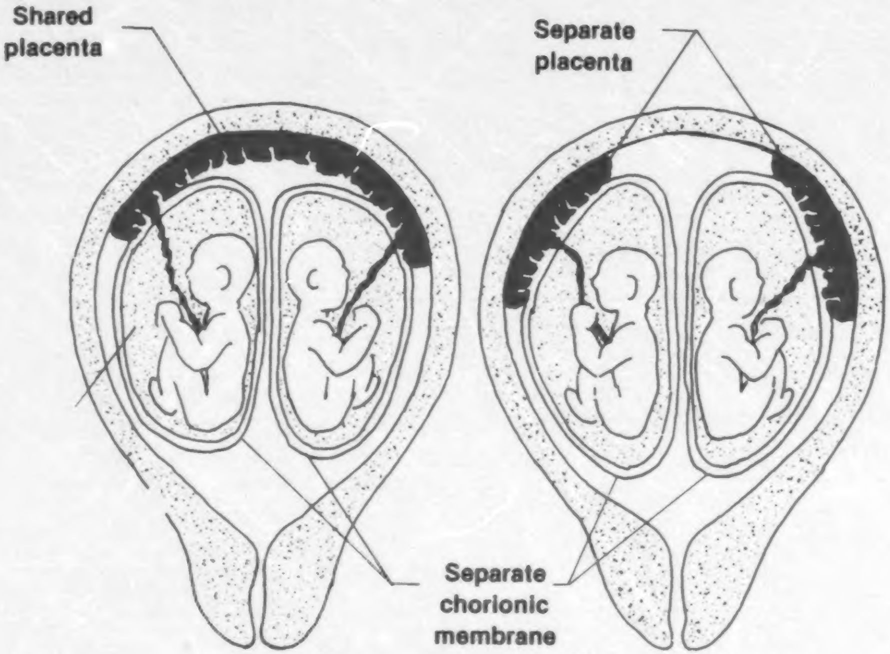
Multiple Births

"Multiple births" is a term that means having more than one baby at the time of delivery. Twins are the most common form of multiple births, occurring 1 in 90 births. Triplets are born 1 in 8,000 births. Quadruplets are born 1 in every 500,000 births. There are two types of twins, identical and fraternal.


Shared placenta
Separate amniotic sac
Shared chorionic membrane

Identical Twins

Identical twins look alike and are always the same sex. They develop from one egg cell that was fertilized by one sperm cell. They share the same placenta and chorionic sac. Each twin has his/her own umbilical cord and amniotic sac.


Shared placenta
Separate placenta
Separate chorionic membrane

Fraternal Twins

Fraternal twins do not look any more alike than any brothers and sisters because they develop from two individual egg cells that were fertilized by two different sperm cells. They may or may not be the same sex. Each twin has his/her own cord, chorionic and amniotic sacs, and placenta. Sometimes the placentas grow together and appear to be one.

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Chapter Four

"YOUR HEALTH CARE DURING PREGNANCY"

Pages 21-23

About the chapter

Medical care during pregnancy should begin early and continue regularly. This is especially true for pregnant adolescents, who are considered to be in the high-risk medical category. When adolescents receive adequate prenatal care, the incidence of complications is reduced. In fact if the young woman is over 15, receives consistent prenatal care, and has adequate nutritional intake, her incidence for complications is no greater than for pregnant women in the general population.

Health Care Providers

There is a trend in our society for routine obstetrical care to be provided by a variety of specially trained health care professionals. Besides the family doctor and obstetrician, there are certified nurse-midwives, family nurse practitioners, women's health specialists, and other specially trained persons. Depending on your own locale, any or all of the above-mentioned persons may be providing prenatal care to pregnant women. Our use of the term "doctor" is in no way intended to minimize the competence of these persons. In our experience young women most often refer to their health care providers as "doctors," regardless of sex or actual training of that person.

The type of health care chosen is largely dependent upon two factors. The first is personal preference. For example, some young women feel far more comfortable with a male. Others, because of embarrassment or cultural taboos, may choose to be examined only by females. If the expectant mother's choices are limited, she may need assistance and support in accepting the type of health care that is available to her.

A second factor affecting the choice of a health care provider is financial. Many young women have severe financial limitations. It is important for you to familiarize yourself with your community's resources to ascertain availability and cost of prenatal care. Find out as soon as possible whether the young woman is receiving prenatal care. If she is not, find out why not. She simply may need your assistance in making the first appointment.

You can facilitate the teenager's relationship with her health care provider. She may feel awkward and uncomfortable asking questions. Encourage her to make lists of her questions and concerns between visits, and check with her following her visits to make sure she has understood the answers she has received and the instructions for her care. Your attitude towards the importance of health care may influence both her willingness to keep appointments and her attitude towards medical care. If she has a positive experience now, she will be more likely to value regular health care visits for herself and her child later.

Those of you who work in health care settings can be of valuable support to a young woman. You're in a position to influence positively her childbearing experience as well as the outcome of the pregnancy for both mother and child. Pregnant teens tell us that the attitude of their health care providers has a profound effect on their attitudes related to pregnancy and childbirth. The health care providers who have a positive influence on young women tend to show sincere respect, to take time for answering questions and explaining procedures, and to use terminology that is easily understood. Prenatal care can be viewed as a negative experience when these qualities are absent.

The pregnant teen may experience ambivalent feelings about her pregnancy and may need reassurance. She may also need the opportunity to discuss her fears related to pregnancy, childbirth, or parenthood. The health care provider may be in a unique situation to evaluate the mother's potential for bonding with her child and her potential for providing adequate nurturing. There are some signs you can look for that indicate positive movement in that direction. Positive indications include following instructions, keeping clinic appointments, and showing other signs of responsible prenatal care. Positive attitudes are indicated by personal references toward the child ("*My* little baby," "He's going to be a football player," etc.). Impersonal references to the unborn child, such as "This lump in my stomach," indicate that the mother may have difficulty in accepting the child. Other signs of negativity include heavy alcohol or drug use, poor health habits, refusal to gain weight, and/or repeated failure to behave responsibly. Negative circumstances in other areas of her life may also contribute to a poor outcome. Early intervention may prevent future problems. If you see negative indications and are not in a position to handle the situation in your own setting, make an appropriate referral.

Expanded Content

Additional content of a medical nature may assist you in teaching this chapter.

Rubella (German measles)

Rubella is a mild disease of short duration that can cause severe congenital anomalies in an unborn child. If the disease is contracted by the mother during the first three months of pregnancy, the possibility of damage to the baby is high. The organs damaged are the ones undergoing rapid growth at the time the mother has the disease. Exposure to rubella will not cause birth defects; the pregnant woman must *have* the disease before this danger exists. Fortunately, most young women have received the rubella immunization prior to pregnancy and are thus protected from this damaging disease. If the blood test to determine the rubella titer shows no immunity, the young woman should receive the rubella immunization after delivery and before she leaves the hospital. Because the rubella vaccine is a live virus, it is not given during pregnancy.

RH Factor

The Rh factor is a protein in the blood that is found in 85 percent of the population, the Rh positives (Rh +). Fifteen percent of the population having no such factor is Rh negative (Rh-). The Rh factor is significant during pregnancy if there is an incompatibility between the Rh- mother's blood and that of her unborn. If *both* parents are Rh + or Rh-, there is no danger to the unborn baby. There is potential danger if the mother is Rh-, the father is Rh +, and the child is Rh +.

Potential harm occurs when some of the child's Rh + factors get into the mother's Rh- blood stream (usually during delivery after the placenta separates from the uterine wall). The mother's blood reacts by producing antibodies to destroy the foreign Rh factors. Because the child's Rh + factors usually do not get into the mother's blood stream until delivery, there is little danger to the first baby. During subsequent pregnancies, however, the mother's antibodies can cross the placenta to the unborn child's blood stream and can destroy the baby's red blood cells. Destruction of red blood cells can lead to severe jaundice, brain damage, or death. These bad effects can be prevented through the administration of an anti-Rh "antibody" called Rhogam. Rhogam is injected into the Rh- mother's blood within 48 hours after delivery if the baby is Rh +. The mother's system then cannot make the dangerous antibodies, thus preventing harm to her next unborn child. Rhogam is also given to Rh- women following miscarriages or abortions as sensitization can occur at those times. Rhogam cannot be given to women already Rh + sensitized from a previous pregnancy.

Vaginal Infections

The body changes that occur during pregnancy make pregnant women more susceptible to vaginal infections. Although there normally is an increase in vaginal discharge during pregnancy, discharge is considered to be abnormal if it causes itching, swelling, or irritation; if it has a foul or unpleasant odor; or if it becomes excessive.

The two most common types of vaginal infections are monilia ("yeast") and trichomonas ("trick"). These vaginal infections are not dangerous venereal diseases. Trichomonas may cause a greenish-yellow, foamy discharge; whereas monilia may cause a thick, white curdlike discharge.

Young woman may be hesitant to mention signs of infection to their health care providers because they fear they have a serious venereal disease. Although not serious, both infections must be treated by a qualified health professional. A young woman can more easily discuss her symptoms if she understands that both diseases are common during pregnancy and should be treated.

Toxemia

Toxemia is a medical condition that occurs most frequently in first pregnancies. The condition is divided into two categories, pre-eclampsia and eclampsia. Pre-eclampsia begins after the 20th week of pregnancy and is characterized by an elevated blood pressure. Two other symptoms that often accompany pre-eclampsia are a rapid weight gain due to fluid retention and proteinuria (albumin in the urine). Eclampsia, the advanced state of toxemia, is characterized by seizures and rarely occurs when pre-eclampsia is treated. The cause of toxemia is unknown.

Treatment is usually started when a slight elevation in the blood pressure is detected. The primary treatment, geared toward the prevention of symptoms, is bedrest. Patients are usually instructed to rest on their left sides once or twice a day for at least 20 minutes. Restng in this position increases the blood flow to the uterus and kidneys. If the symptoms cannot be controlled through bedrest, hospitalization will be required. The only known true cure for toxemia is delivery of the baby

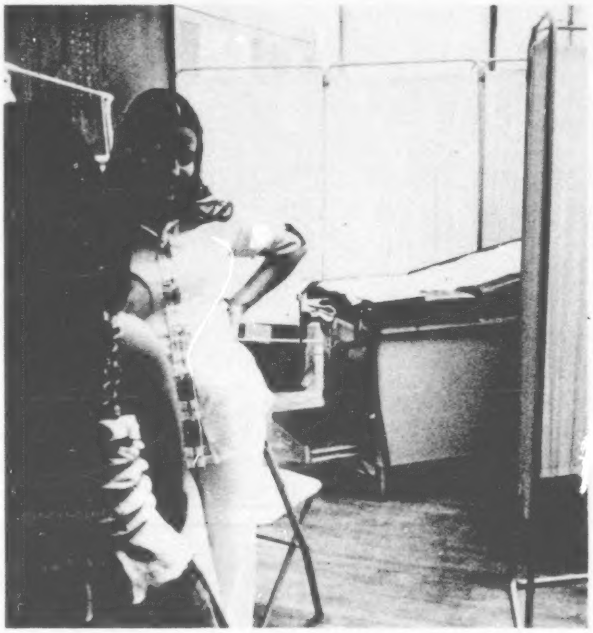
Medical Tests

There are several medical tests that may be done during pregnancy to give doctors information about the health of their patients. The O.C.T. (Oxytocin Challenge Test), which is sometimes called the C.S.T. (Contraction Stress Test), may be given to a woman when her health care provider suspects she may be past her due date. The O.C.T. may also be utilized any time a health care provider suspects inadequate placental functioning such as in cases of diabetes or hypertension.

The O.C.T. is generally a hospital outpatient procedure. A small amount of oxytocin is introduced into the patient's blood stream to stimulate uterine contractions. The contractions and fetal heart beat are then monitored on a machine. If the placenta is functioning normally, the contractions have no effect on the fetal heart rate. If the placenta is not functioning normally, the fetus receives an inadequate amount of oxygen during a contraction. The result is a slowing of the fetal heart rate in a specific pattern. Because there are other types of slowing of the fetal heart rate that may be normal, this test must be interpreted by a trained person. If the placenta is functioning poorly, the baby should be delivered as soon as possible either through induction of labor or by a Cesarean section.

Another test that may be done on a pregnant woman is the sonogram (sometimes called a B-scan or Real time). Sonograms utilize ultrasound equipment to visualize the fetus and placenta inside the uterus. Leads from the sonographic equipment are placed on the woman's abdomen and are neither painful nor thought to be dangerous to the unborn child. Ultrasound waves reflect off the uterine contents and project a picture onto the screen of the monitor. The head size and position of the baby as well as the position of the placenta can be determined.

Indications for use of the sonogram include
(1) uncertain length of gestation,
(2) possibility of multiple births,
(3) concern for course of fetal development,
(4) placenta previa (position of the placenta near to or covering the cervical opening), and
(5) placenta abruptio (premature separation of the placenta from the wall of the uterus).



I. Chapter Goals
  A. To motivate the young mother to obtain early and continued health care
  B. To provide information about prenatal medical care and to promote the establishment of a positive relationship between the patient and her health care providers.

II. Important Concepts

A. Early and continued prenatal care by a qualified health care provider is of extreme importance to the health of both mother and unborn baby.

B. Teenage mothers are often at risk nutritionally due to poor dietary habits.

C. The better informed the patient, the more she can benefit from medical care and relate to health care providers.

D. The teenage girl may be at risk medically in pregnancy due to physical and emotional immaturity.

III. Learning Objectives

The student will be able to do the following:

A. Explain the importance of early and continued prenatal care to mother and unborn baby;

B. List four blood tests that are done at the beginning of pregnancy;

C. Define desirable weight gain in pregnancy and describe the dangers of inadequate weight gain;

D. List four reasons why the doctor does a pelvic examination at the first prenatal visit.

IV. Content Overview

Text Page

A. Importance of prenatal care 21

B. Medical history 21
   1. Health questions
   2. Menstrual history
   3. EDC

C. Urine test 21
   1. Sugar may indicate a pre-diabetic condition.
   2. Albumin may be indicative of toxemia.

D. Blood tests 21
   1. VDRL
   2. Hemoglobin
   3. Blood type
   4. Rh factor
   5. Rubella titer

E. Weight gain 21, 22
   1. Variance due to weight at time of conception
   2. Doctors' recommendations variable

F. Blood pressure 22

G. Complete physical exam 22

H. Pelvic exam 22
   1. Signs of pregnancy
   2. Signs of infection
   3. Pap smear
   4. Gonorrhea test
   5. Pelvic measurements

I. Return visits 23

J. Importance of asking questions 23

V. Suggested Learning Activities

A. Think back on first visit to the doctor. Discuss, as if on a "guided tour," happenings, feelings, and the importance of the procedures. (Many women feel embarrassed and shy as patients and for this reason often avoid medical care.)

B. Role-play visits to the doctor.

C. Calculate EDC ("due date").

Example:

First day of last menstrual period	= June 10
Add 7 days	+ 7
Subtract 3 months	– 3 months
EDC	= March 17

D. Invite a doctor, midwife, or obstetric nurse to class to discuss prenatal care as well as responsible health care (such as self breast exam, signs of infection, etc.).

E. Bring to class and examine instruments and equipment used in prenatal exam.

F. Discuss or answer in writing the questions in part VI.

VI. Questions for Discussion/Study Guide

A. Why is it important for a woman to see a doctor early and regularly during her pregnancy?

B. List four blood tests that will be done during your first visit to the doctor.

C. About how much weight should you gain during pregnancy?

D. What are the dangers of not gaining enough weight?

E. List four reasons why a pelvic exam will be done on your first visit to the doctor.

VII. Resource Materials

A. Films: *Your Pelvic and Breast Exam*

B. Chart: "The Female Reproductive System: Illustrations for Patient Counseling," G.D. Searle and Co.

C. Pamphlets:
   1. *Be Good to Your Baby Before It's Born*, March of Dimes
   2. *For Your Information . . . Vaginitis*, Ortho
   3. *Nearly Every Woman Gets It*, Planned Parenthood of New York
   4. *Pap Smear: What Is It?*, American Cancer Society
   5. *Prenatal Care*, DHEW # (OCD) 73-17
   6. *Understanding Your Vaginal Discharge*, G.D. Searle and Co.

D. Book: *Your Pregnancy Month by Month*, Gillespie

Chapter Five

"KEEPING YOURSELF WELL DURING PREGNANCY"

Pages 24-30

About the Chapter

As the title of this chapter indicates, we have presented pregnancy as a normal, natural, and healthy state. It is true that some women seem to feel better during this time than others. Much of this has to do with the woman's attitude toward herself and the pregnancy as well as with how well she takes care of herself.

As we have mentioned earlier, there are many customs and taboos related to the well-being of both the mother and baby. When dealing with the information in this chapter, it is important for you to find out what customs are practiced in your area. Many of these seem to be effective; and if they are a part of the belief system of the woman, they can be integrated with her health-care practices. If the values and beliefs of a young woman can be integrated with what is taught from a medical viewpoint, there is a greater chance that she will continue to do everything possible to affect positively the outcome of her pregnancy.

We have presented the most basic information related to personal care and common discomforts during pregnancy. When we taught this subject matter, we gained some additional insights and bits of information that you may find helpful. This list is by no means intended to be comprehensive, but it may alert you to some things that we found out through experience.

Rest and Sleep

There are two very prevalent myths related to rest. Some young women are taught that if the mother sleeps too much, the baby will stick to her back, causing a long and difficult labor. The other misconception is similar. It is said that resting during pregnancy will cause the mother to become irreparably lazy.

The amount of rest and sleep the pregnant woman needs will be affected by her stage of pregnancy as well as by her level of activity. Sleepiness and fatigue are quite common during the first trimester. As the basal metabolism rate increases during the second trimester, the young woman will feel more energetic. The difficulty of finding a comfortable sleeping position during the last trimester can once again increase the need for rest periods during the day.

Bathing

There is some difference of opinion among health care providers as to the frequency and type of bathing that is appropriate. In general, there is an increased amount of perspiration and resulting odor during pregnancy. On the other hand, some women find that the skin becomes excessively dry during this time. When discussing this topic, you will want to take into consideration the fact that many homes have neither tubs nor running water. Discuss the sponge bath as an alternative method of bathing. If a woman's hygienic practices are sound, she can continue with her regular habits.

Some bubble bath preparations (example: Mr. Bubble) can be potentially harmful. In addition to skin irritations, these products have been known to cause urinary tract infections.

Breasts

It is very tempting for a young woman to go without a bra during pregnancy. It's her choice. It should be emphasized, however, that not wearing a bra will increase the danger of sagging later. In addition, it is important to alert the woman to the fact that her breasts will change contour somewhat as a result of having been pregnant.

Teeth and Gums

Red, swollen, sensitive gums are a result of hormonal changes and increased fluid retention. Brushing with a hard bristle brush from side to side will cause the gums to recede, exposing sensitive areas above the teeth. Reinforce the fact that brushing should be done with a soft brush in an up-and-down motion.

Sexual Relations

How much you discuss the topic of sex during pregnancy will depend upon whether or not a young woman has an ongoing relationship with a partner. If you are teaching in a classroom, you may have some young women who are sexually active and others who are not. For this reason it may be preferable to discuss the topic on a one-to-one basis to allow for individual needs.

In general, sexual intercourse during pregnancy is not considered dangerous. There are some cautions, however, of which you should be aware. For example, a young woman should abstain from intercourse if she is bleeding or experiences pain as a result. Increased abdominal pressure due to the enlargement of the uterus is common and is not cause to discontinue intercourse. A change to a side-lying position may be more comfortable. Blowing into the vagina can be extremely dangerous, as it can cause an air embolism within the uterus, resulting in potential harm or even death to the mother and fetus.

Interest in sexual activity may be influenced by pregnancy. Some women report that they experience a marked increase in libido. Others have a diminished interest in sex during pregnancy. This decrease in interest may be a serious concern for these young women and their partners. Reassure them that this condition is temporary, and urge them to discuss it with their partners. You may want to discuss with them that there are many ways to experience physical closeness and intimacy.

Exercise and Sports

There is considerable variation in opinion as to the appropriateness of sports and other physical activity. In general, activities that could result in a fall or blow to the abdomen should be discouraged. If there is any doubt, refer the question to the health care provider.

If you are in a classroom setting, prenatal exercises can be taught and practiced as a group. Group exercises are good icebreakers and can be a lot of fun. Your own willingness to participate and have fun will help alleviate the embarrassment of your students.

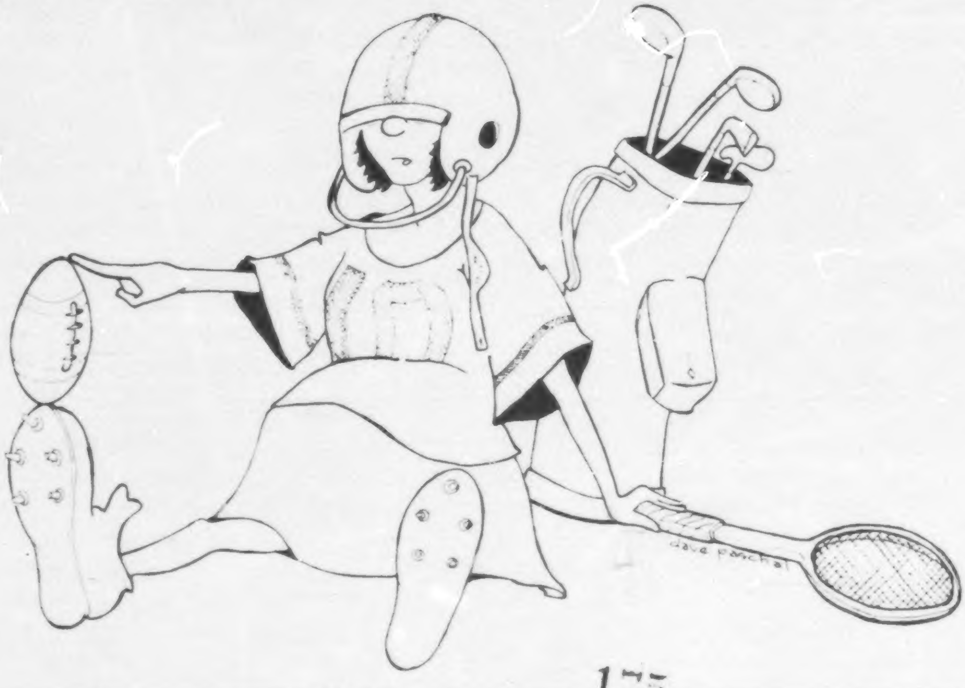
If a young woman with whom you are working is not getting prenatal exercise instruction, encourage her to sign up for a class. Many communities offer such classes, and your local hospital or clinic should have more information. In some areas yoga classes are offered.

Douching

Unless instructed otherwise, a woman should not douche during pregnancy. *Douching is not recommended at any time,* as it alters the normal bacterial flora present in the vagina, increasing the risk of vaginal infection. The source of vaginal odor is external; therefore, regular washing is adequate. If a young woman chooses to douche when she is not pregnant, she should definitely avoid the scented, flavored preparations.

"Morning Sickness"

Nausea and vomiting may be caused by a slowdown of the digestive system or by an



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empty stomach. Feeling "upset" about the pregnancy or some other source of stress may cause stomach upset. Excess nausea and vomiting ("hyperemesis gravidarum") can be a danger sign and should be reported to the doctor or clinic. Vomiting is considered to be excessive if it continues beyond the fourth month and/or if it occurs after every meal. Discourage the use of across-the-counter remedies for indigestion.

Dizzy Spells

Dizziness is usually related to circulatory changes that accompany pregnancy or to an empty stomach. If a young woman feels dizzy, have her sit with her head between her knees. If she faints, prop her feet higher than her head. It is a good idea to keep some smelling salts or ammonia on hand. A quick whiff under the nose should revive her immediately. Ask whether she has eaten. If the room is hot, ensure adequate ventilation. Most of all, keep yourself calm so that you can reassure her!

Frequent Urination

Encourage intake of fluids that are of a nutritious nature (juice, milk, etc.), rather than ones high in caffeine or sugar (coffee, tea, or soft drinks.)

Constipation

Constipation is related to pressure of the growing uterus against the colon and to the slowdown in the digestive system. Some laxatives (Ex-Lax) work by causing the intestine to cramp. These are dangerous during pregnancy because they can cause irritation to the uterine muscle. Others, such as epsom salts, cause fluid imbalance in the body. In general, it is *not* recommended to use over-the-counter drugs.

Heartburn

As far as we know, heartburn does *not* indicate that the unborn baby has a thick head of hair! Nor does it have anything to do with one's heart. Home remedies such as baking soda in water or commercial preparations such as Alka Seltzer or Rolaids should not be taken because of their high sodium content. Although there is controversy over the amount of sodium a pregnant woman should consume, remedies containing high amounts of sodium are usually discouraged.

Muscle Cramps

A "stitch" or a cramp in the round ligament that supports the uterus is a common ailment that often causes concern. The young mother may fear she is in premature labor or is having a miscarriage.

Vaginal Discharge

The heavy whitish discharge in pregnancy ("leukorrhea") results from an increase in hormones. It is not to be confused with signs of infection as described in Chapter 4.

Stretch Marks

Teenagers may attempt to restrict weight gain to prevent stretch marks. Since these are caused by hormonal changes affecting the elasticity of the skin, it should be emphasized that such attempts will not work. To alleviate dryness and itching of the skin, less expensive preparations such as lanolin or cocoa butter are just as effective as the expensive "special potions" sold for this purpose.

Stuffy Nose

Unprescribed nosedrops should be avoided, as they can be addictive. Bloody noses are very common. To stop a nosebleed, tilt the head back slightly and apply pressure to the upper nose.

Hemorrhoids

Hemorrhoids are varicose veins around the rectum. Due to the pressure of the enlarged uterus, they can occur at any time during pregnancy. They may develop during delivery as a result of pushing.

Varicose Veins

Support hose made for maternity use help alleviate the swelling and discomfort of varicose veins. Some teens are reluctant to wear support hose, but they can be worn under jeans or slacks without being seen. If her legs are hurting or if the veins are quite obvious, encourage the young woman to get medical advice.

Differentiating Complaints From Danger Signs

The common complaints experienced during pregnancy are often confused with danger signs. It can be reassuring to a pregnant woman to learn that most of her complaints, though annoying, are not dangerous. On the other hand, it is important for her to learn which signs can indicate complications so that medical advice can be sought immediately.

Miscarriage

The spontaneous abortion (the medical term for miscarriage) rate is somewhat higher among pregnant adolescents than in the older maternal population. Researchers disagree as to the exact percentage; but there is agreement that the younger the teen, the higher the risk.

When working with a class of pregnant adolescents, it is quite possible that at least one of the young women may have had a previous miscarriage. It is also possible that someone may miscarry during her current pregnancy. Questions showing anxiety and fear often arise. You may want to discuss with the class that the usual signs of an impending miscarriage include bleeding, cramping, and the passage of clots and tissue. Perhaps most important will be your reassurance that one miscarriage does not necessarily mean that the next pregnancy will result in miscarriage. As a matter of fact, it is quite likely that the next pregnancy will be normal and healthy!

There is some disagreement in the medical field regarding the level of activity that is appropriate for a woman who is threatening to miscarry. One school of thought is that activities should be restricted and/or complete bedrest advised. Others believe that a woman should be allowed to continue with her regular activities with the viewpoint that if she is going to miscarry, bedrest won't help. The woman's medical history and current condition may influence the doctor's advice. If miscarriage appears to be a threat in a young woman with whom you are working, encourage her to rest in bed until she has the opportunity to see her health care provider.

A teenager may want to miscarry and, therefore, may not follow the doctor's instructions. The person working with this young woman needs to be sensitive to the woman's desires as well as in touch with her *own* personal feelings. It could be very easy to lay a guilt trip on the young woman.

I. Chapter Goals

A. To provide accurate information needed to understand and cope with the physical changes and common complaints related to pregnancy
B. To promote the practice of good prenatal care for greater comfort and stability during pregnancy
C. To alert the expectant mother to the warning signs that may be indicative of complications during pregnancy

II. Important Concepts

A. Pregnancy and childbirth are normal functions of the human female.
B. The health of the pregnant individual and her unborn child are dependent to some extent on her knowledge of normal body functions and sound health practices.
C. The normal physical changes of pregnancy may be accompanied by annoying symptoms and complaints.
D. Many of the common complaints of pregnancy can be treated by dietary changes, exercise, and a change in sleeping position.
E. Early detection and reporting of the danger signs in pregnancy may prevent serious medical problems for the mother and baby.

III. Learning Objectives

The student will be able to do the following:

A. Explain personal care related to rest, bathing, clothing, breasts, teeth, work, travel, sexual relations, exercise and sports, and douching;
B. List four common discomforts of pregnancy that can be helped by changes in diet, and outline the changes necessary;
C. List three discomforts of pregnancy that can be helped by prenatal exercises and body position;
D. List nine warning signs that should be reported to the health care provider.

IV. Content Overview

Text Page

A. Personal care 24-26
   1. Rest and sleep
   2. Bathing
   3. Clothing
   4. Breast care
   5. Teeth
   6. Work
   7. Travel
   8. Sexual intercourse
   9. Exercise and sports
   10. Douching
B. Common complaints............... 27-29
   1. Nausea and vomiting
   2. Dizzy spells
   3. Frequent urination
   4. Constipation
   5. Heartburn
   6. Muscle cramps
   7. Backache
   8. Vaginal discharge
   9. Stretch marks
   10. Stuffy nose
   11. Hemorrhoids
   12. Varicose veins
   13. Shortness of breath
   14. Mask of pregnancy
C. Pregnancy as a natural, healthy condition.................... 29
   1. Discomforts are *not* danger signals.
   2. The average individual will experience only a few discomforts.
   3. Prevention and alleviation of discomforts are usually related to diet, rest, posture, and exercise — *not* medication
D. Warning signs........................ 30
   1. Swelling in face, hands, and/or feet results from fluid retention and may indicate toxemia.

2. Blurred vision or spots before the eyes may be indicative of high blood pressure and possibly toxemia.
3. Bleeding from the vagina can be a sign of miscarriage or placental dysfunction.
4. Severe or constant headaches can also be a sign of high blood pressure or toxemia.
5. Severe or continuous vomiting can lead to dehydration and dietary deficiencies.
6. Fever and chills may indicate an infection.
7. Burning and pain upon urination usually indicate a bladder or kidney infection.
8. Sharp, constant pain in the abdomen is extremely dangerous and is a sign of advanced toxemia.
9. A suddeh gush or steady trickle of fluid from the vagina may indicate premature breaking of the bag of water.

E. Miscarriage 30

V. Suggested Learning Activities

A. Write anonymous questions on slips of paper and answer as a group, aloud. This activity is helpful for questions related to love-making and other sensitive issues.

B. Make posters about personal care by cutting out or drawing pictures. (Example: safe or unsafe sports, comfortable versus restrictive clothing, etc.)

C. Visit second-hand stores and/or maternity shops to compare prices.

D. Examine samples of supportive bras and nursing bras. Undergarment sales-persons are often willing to lend these for classroom purposes. Discuss best methods of putting on bras.

E. Examine labels on paints, cleaners, etc., for warnings.

F. Distribute 3"x5" cards, each containing a question related to personal care or common complaints Students answer *on the card.* Cards are collected and redistributed so that students read aloud someone else's answer and discuss as a group, thus minimizing the fear of being wrong.

G. Demonstrate exercises that alleviate complaints; then have students practice the exercises.

H. Borrow maternity clothes from stores for students to model, and discuss in class. Stores are usually very cooperative if they understand the purpose.

I. Discuss creative ways of adapting regular clothes for maternity wear. Often you can get donations for this purpose, and students enjoy it.

J. Invite a dentist to talk to the class about dental care during pregnancy.

K. Encourage students to offer suggestions as to *other* remedies and common folk beliefs. An atmosphere of acceptance is essential here! Don't discount beliefs. It is helpful to research this topic ahead of time.

L. Discuss or answer in writing the questions in part VI.

VI. Questions for Discussion/Study Guide

A. What advice would you give a pregnant woman about each of the following:
1. Rest
2. Bathing
3. Clothing
4. Breasts
5. Teeth
6. Housework
7. Travel
8. Sexual relations
9. Exercise and sports
10. Douching

B. Many of the things that bother a pregnant woman (common complaints) can be helped by changes in how she eats. Name four complaints and tell what changes she should make in her diet.

C. Other complaints can be helped by prenatal exercise and good posture. Name three complaints and tell which exercises will help.

D. Of all the common complaints, which one(s) has bothered you the most? What have you found that has helped?

E. List nine danger signs of pregnancy that should be reported to the doctor.

F. Have *you* had any of these warning signs? What did the doctor tell you about them?

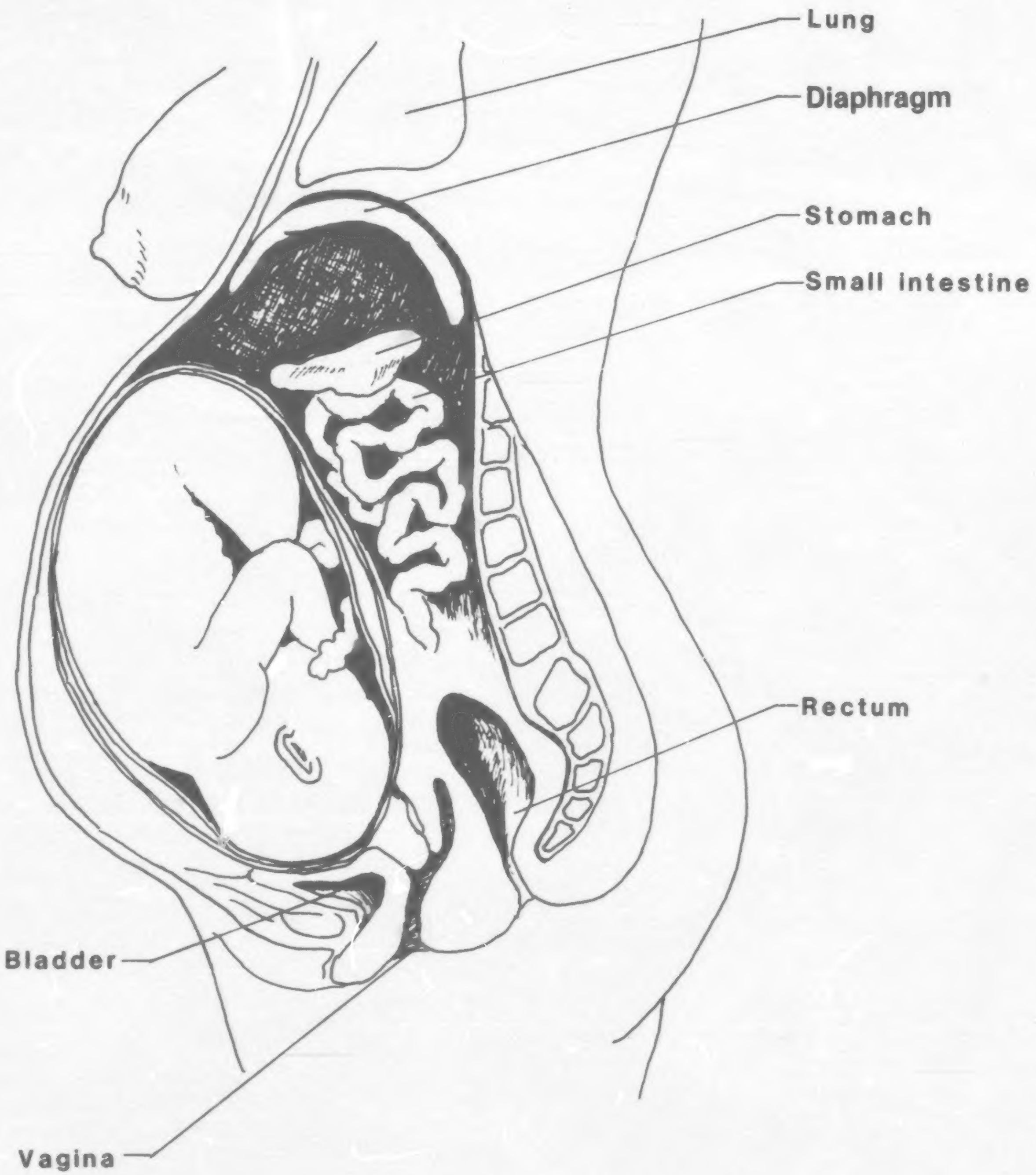
VII. Resource Materials

A. Film: *Nine Months in Motion*

B. Pamphlets:
1. *Be Good to Your Baby Before It's Born,* March of Dimes
2. *Care for You and Your Baby-to-Be,* Ross
3. *Sexual Relations During Pregnancy and the Post-Delivery Period,* Siecus
4. *What to Do About the Minor Discomforts of Pregnancy,* Ross

C. Book: *Your Pregnancy, Month by Month,* Gillespie

Relationship of the Developing Baby to the Organs in the Mother's Body


Lung
Diaphragm
Stomach
Small intestine
Rectum
Bladder
Vagina

Many of the common complaints of pregnancy are caused by the crowding of the organs by the enlarged uterus. Some of these include: 1) constipation, 2) urinary frequency, 3) heartburn, and 4) shortness of breath.

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Chapter Six

"BE GOOD TO THE BABY BEFORE HE'S BORN"

Pages 31-33

About the Chapter

To have a healthy baby, a woman needs to incorporate many positive health care practices into her life. She should also eliminate any dangerous aspects of daily living that could cause possible harm to her unborn child. Such habits as *excessive* smoking, alcohol consumption, or taking drugs not prescribed by one's health care provider have been known to cause poor fetal outcomes.

In this chapter it is our intention to alert the mother-to-be to some of these potential dangers rather than to provide detailed medical information. Research continually provides us with new and updated information related to birth defects, their causes, and prevention. Still, relatively little is known about the effects that result from the use of alcohol, drugs, and tobacco during pregnancy.

Our students expressed considerable interest in this topic and were eager to know *exactly* what results they could expect from the uses of various drugs at various times. Over and over again, we found ourselves unable to answer this question because the outcome was not certain until the child was born or even later. The risks are great enough, however, that young mothers should be urged to be very cautious.

Needless to say, this issue can be extremely delicate! If a young woman has already engaged in practices that may have jeopardized the well-being of her child, a discussion of birth defects can be quite frightening. She will need reassurance that the baby will probably be all right. On the other hand, it is equally important that she understand the dangers and take responsible precautions for the rest of her pregnancy. For this reason we recommend that you pursue this topic with caution and provide the opportunity for individual conferences.

An excellent resource for current information, films, and materials is the March of Dimes Birth Defects Foundation. In addition to their very active role in the research and prevention of birth defects, MOD has been actively involved in the teenage pregnancy field. We encourage you to be in contact with either your local chapter or the national organization as they can be highly valuable resources. The information we will include here comes primarily from March of Dimes. The pamphlets listed at the end of this chapter will provide you with additional data.

Smoking

According to the August, 1979, Surgeon General's Report on Smoking and Health, the more a mother smokes, the less her baby can be expected to weigh at birth. Twice as many low birthweight babies are born to mothers who smoke than to those who do not. "Studies of long-term growth and development have indicated that smoking during pregnancy may affect physical growth, mental development, and behavioral characteristics of children, at least up to the age of 11." There also seems to be a connection between mothers who smoke during pregnancy and hyperkinesis in their children. Some reports link smoking to Sudden Infant Death Syndrome. The perinatal death rates are significantly higher for infants born to smoking mothers.

Regarding defects, the report concludes, "There is no convincing evidence that maternal smoking increases the incidence of congenital malformations." Young women should be urged to quit smoking during early pregnancy, as smoking is considered especially harmful during the second half of pregnancy.

(Reprints of Chapter 8 of the Surgeon General's Report on Smoking and Health, "Pregnancy and Infant Health," are available from the Office of Smoking and Health, Room 1-58, Park Building, 5600 Fishers Lane, Rockville, Maryland 20857.)

Drugs

The term "drugs" as used here includes not only illicit street drugs but also across-the-counter and prescription drugs. Drugs in all three of these categories are potentially harmful to the unborn baby.

If a woman is accustomed to taking prescription drugs prior to pregnancy, she may not consider the possibility that these could be dangerous to the baby. The mother may even unknowingly compound the risks by taking two or more drugs at the same time, resulting in an unexpected reaction. It is a good idea to remind a young woman not to take any prescription drugs without first checking with her doctor.

One of the most commonly used over-the-counter drugs is aspirin. Frequent use of this seemingly innocent little white pill late in pregnancy can interfere with a baby's blood clotting mechanism. It can also cause the same problem in the mother at delivery. Other commonly used medicines such as laxatives, antacids, and nose drops should also be used with extreme caution (see Chapter 5).

You should be alert to the fact that many teenagers have been exposed to street drugs. The level of use may vary from one time only to heavy habitual consumption. If a young woman has been using hallucinogens, narcotics, amphetamines, or barbituates during her pregnancy, she should be encouraged to discuss this fact with her health care provider! Scientists do not yet know the exact effects of all these drugs. Women who are addicted to or are heavily dependent upon drugs, however, tend to neglect their own health and, consequently, the health of the child. Mothers addicted to heroin have babies who are also addicted and who must undergo withdrawal after birth.

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Alcohol

Heavy drinking among adolescents is on the increase and is cause for concern. Children born to heavy drinkers may be born with "fetal alcohol syndrome," a condition characterized by severe growth deficiency, heart defects, and malformations in the head and face. Some researchers link alcoholism during pregnancy to mental retardation. Currently research is being done to ascertain the effects of limited alcohol consumption on the fetus. Students should be cautioned that mixing alcohol with either prescription or non-prescription drugs can be dangerous.

It should be emphasized that drugs have such a profound effect on unborn babies because they are so small and have such immature systems. Even though a drug may not have much effect on the mother, it can have a much greater effect on the fetus.

Common Misconceptions

The section entitled "Don't Believe Everything You Hear" lists some of the most commonly held misconceptions related to pregnancy and childbirth. There is a thin line between acceptable cultural beliefs and harmful misconceptions. It is necessary to dispel only those beliefs that have dangerous implications for either the mother or her baby. Your attitude of acceptance will help the young woman incorporate her cultural traditions with sound health care practices.

I. Chapter Goals
  A. To provide information regarding potential dangers to the unborn baby
  B. To explore common misconceptions regarding pregnancy and childbirth

II. Important Concepts
  A. The way an expectant mother takes care of herself relates directly to the outcome of pregnancy.
  B. There is scientific evidence to indicate that alcohol intake, smoking, drugs, x-rays, venereal disease, rubella, and

dietary deficiencies can adversely affect fetal outcome.

III. Learning Objectives

The student will be able to do the following:

A. List six dangers to the unborn baby and their possible effects;

B. List three misconceptions related to pregnancy and childbirth.

IV. Content Overview

	Text Page
A. Dangers to developing fetus	31-33
1. Smoking	
2. Drugs	
3. X-rays	
4. Alcohol	
5. Rubella and other infectious diseases	
6. Venereal disease	
7. Dietary deficiency	
B. Common misconceptions related to pregnancy and childbirth	33

V. Suggested Learning Activities

A. Answer one or more of the following letters:
  1. "I am pregnant and smoke a pack of cigarettes a day. Will this hurt my baby? If so, how? What should I do?"
  2. "I had X-rays during my sixth month of pregnancy. Could this have hurt my baby? If so, how?"
  3. "I am addicted to heroin. What does this do to my baby? Is there anything I should do?"
  4. "I am a heavy drinker on the weekends. Can this harm my baby? What do you think I should do?"
  5. "My boyfriend says he has gonorrhea, but I don't have any signs. Could I have it? Could it hurt the baby? How? What should I do?"
  6. "I am pregnant and my little brother has German measles. I've heard that can hurt my baby. Is it true? What should I do?"
  7. "I live on Cokes, candy, and potato chips. Does this hurt my unborn baby? What do you think I should do?"

  (Note: Use MOD pamphlets as student resources for this activity. Share responses in classroom.)

B. Discuss in pairs what each is doing to help make sure her baby will be born healthy.

C. View films on dangers to the unborn baby and preventive measures.

D. Invite speakers to talk to the class on V.D., alcohol, drugs, smoking, etc.

E. Encourage students to discuss other things they have heard about pregnancy or other things that will affect the unborn child.

F. Discuss or answer in writing the questions in part VI.

VI. Questions for Discussion/Study Guide

A. List six things that are dangerous to the unborn child and tell how each might hurt him.

B. What is venereal disease? How do you get it?
  1. How does syphilis affect the unborn baby?
  2. How does gonorrhea affect the baby?

C. What are *you* doing to have a healthy baby?

D. What other things have you heard of that might hurt the unborn baby?

E. Are you currently using any drugs, drinking alcohol, or smoking?

VII. Resource Materials

A. Films:
  1. *Alcohol: Crisis for the Unborn*
  2. *Born Hooked*
  3. *The Choice*
  4. *Have a Healthy Baby: Pregnancy*
  5. *Look What's Going Around* (V.D.)
  6. *Venereal Diseases*

B. Filmstrip/Cassette: "Tomorrow Happens Today" (This resource very graphically shows the harm to the unborn baby from German measles, syphilis, thalidomide, etc. Preview before showing and follow with a reassuring discussion!)

C. Chart: "V.D. Dial," Spenco

D. Pamphlets (all available from March of Dimes):
  1. *Be Good to Your Baby Before It's Born*
  2. *Birth Defects: Tragedy and Hope*
  3. *DATA: Drug, Alcohol, and Tobacco Abuse*
  4. *Facts About Sickle Cell Anemia*
  5. *Facts: 1979*
  6. *Genetic Counseling*
  7. *If You Drink, Your Unborn Baby Does, Too*
  8. *My Child Has Down's Syndrome*
  9. *Nutrition and Pregnancy*
  10. *Preventing Birth Defects Caused by Rubella*
  11. *Venereal Disease Hurts You and the Unborn*
  12. *When a Woman Smokes*, American Cancer Society

E. Book: *Just So It's Healthy*, Robe

Chapter Seven
"EATING FOR TWO"
Pages 34-39

About the Chapter

The nutritional status of a woman prior to conception, during pregnancy, and following delivery affects the well-being of both mother and infant. For this reason women need assistance in learning the basics of good nutrition and in integrating these basics into their own eating habits.

Integration of good nutritional habits is particularly crucial for the very young woman. During the teenage years, considerable growth and development occur. The teenager has increased nutritional and caloric needs in order to support this growth. If the teen is quite active, these demands are even greater. Unfortunately, the eating habits of most teenagers are often inadequate to meet these needs. Teens are notorious for their love of snack foods. In fact the consumption of snacks with friends is often a very important part of a young person's social life. In addition, many teenage girls fall prey to fad diets and to fasting as a means of maintaining slim figures.

During pregnancy nutritional requirements are also greatly increased. The pregnant woman needs additional protein, vitamins, minerals, and calories to support the growth and development of her unborn child. Adequate food intake during pregnancy favorably affects the outcome for both mother and baby.

The pregnant teenager is usually considered "at risk" nutritionally. Because a young woman is often physically immature at the time of conception, her nutritional intake must support not only her baby's growth but her own development as well. Poor eating habits prior to pregnancy further increase the risk.

By the time they reach the teenage years, most young people have been exposed to some form of nutrition education. Judging from their comments this exposure often leaves them with negative feelings about "good nutrition." For this reason the introduction of the topic may be a delicate issue.

We cannot be sure of the reasons for teens' negative attitudes toward the study of nutrition, but we do have some hypotheses. What a person eats, when, how, and with whom are very personal matters. Eating practices begin to formulate very early in childhood and are closely associated with one's family, relationships, customs, economic status, and religious orientation. In short, food preferences and eating habits are often an expression of oneself!

When viewed in this light, we can begin to understand why the study of nutrition may have been a turn-off in the past. The material may have been presented in such a way that the young people had difficulty relating the information to their own values and life patterns. The young person may have difficulty receiving the message as a positive one if it indicates that personal orientation or life-long habits are wrong. Nutrition education may have been perceived as an attempt to alter these habits and/or this orientation. We feel this may be the reason why many young people finish their study of nutrition feeling guilty, insulted, or perhaps indifferent.

When the teenager becomes pregnant, however, she may perceive the study of nutrition in a new way. She may develop new motivations for evaluating her eating habits and implementing the appropriate changes. The more concerned the young woman is about the outcome of her pregnancy and the well-being of her child, the greater her motivation will be.

The attitude and approach of the person who discusses this topic are very important. It is essential that the approach be sensitive with emphasis on the positive. Several considerations will assist you in developing such an approach.

Be aware of variations in food preferences and customs. We have found that young women from minority backgrounds are often reluctant to divulge what they eat. They have seen the pictures on the standard food charts, and they are quite aware that the foods they eat aren't listed! When discussing the concepts of basic nutrition, it is essential to emphasize that there are unlimited approaches to well-balanced eating habits.

In our classes we had students from a variety of cultures. We approached our study of the Basic Four by examining how the foods customarily eaten by various ethnic groups filled the same requirements. Whenever possible, we prepared and sampled these foods. We found our students enjoyed being the experts about their own ethnic foods. Their obvious pride in sharing something special from their own heritage was perhaps even more important. We feel that the study of nutrition can be an excellent opportunity to demonstrate the many different ways in which the same ends can be achieved.

Be sensitive to economic considerations. A large portion of one's income may go for the purchase of food. For the young person, there simply may not be enough money available to purchase all the recommended food items. The young person may feel too embarrassed to admit this.

It is important that you become familiar with the supplemental food programs, such as W.I.C. and Food Stamps, that are available in your own community. Many of the young people with whom you work will need instruction and assistance in utilizing such programs.

In some cases young people may not have the means to refrigerate and/or cook foods. We recommend that you become aware of such factors and assist them in dealing creatively with such conditions. Your own attitude of acceptance and positiveness will be particularly important when working with those who are economically deprived.

Be sensitive to the impact of living situations upon one's eating habits. There may be factors in the young person's living situation that can hinder her making dietary changes. It will be important for you to discuss these practical issues with her. The family structure and hierarchy may inhibit her in a number of ways. Someone over whom the young woman has no control may be selecting and paying for the food. Someone in the home who dislikes the young woman or is punishing her in some way may be preparing the meals. In such cases the young woman will need special assistance in finding ways to improve her diet.

It is also important to find out if a young woman's appetite is being affected by outside circumstances. If she is emotionally upset, she may experience a loss of appetite. She may also be experiencing nausea due to her pregnancy. If you are not adequately trained to assist with these difficulties, we recommend that you make an appropriate referral.

Avoid negativity when discussing nutrition. Whenever possible, accentuate the positives of a young woman's eating habits. Such reinforcement and encouragement is helpful in elevating her sense of self-esteem. She is far more likely to respond to a positive approach than to criticism or negativity! In some instances finding a positive emphasis may be quite a challenge, but you will usually be able to find positives upon which to build.

Keep in mind the social considerations related to teenagers' eating habits. As mentioned earlier, eating is often closely associated with socializing and having fun. The teenager who is pregnant may already be experiencing a sense of difference and isolation from peers. Your approach to nutrition education can aid young people in devising ways of meeting their nutritional needs and meeting their social needs as well. You can serve both purposes by helping them choose snack foods that provide needed nutrients. Also avoid being too dogmatic when suggesting that they cut down on other favorite snacks. Many health care providers and nutritionists agree that extra snacks are not particularly harmful as long as nutritional requirements are being met and weight gain is not excessive.

Be sure your own data is current. The field of nutrition is one in continual flux and evolution. Although the basic concepts seem to remain the same, new data is continually being added. The media adds its influence through educational contributions as well as through advertising propaganda. The field is further confused by food faddists. It may be difficult for the person with limited nutritional training to decipher fact from fiction. Even trained nutritionists disagree on exact methodology and content. We encourage you to seek out reliable sources of information and to keep your approach consistent with that of the health care providers in your community.

Translate your data into concepts that are easy to understand and apply. The study of nutrition is closely linked to biology, chemistry, and anatomy. It is a topic that is potentially complex. Beware of attempting to teach more than your students are able and willing to absorb. We believe it is best to present simple concepts that can be readily understood and applied.

Students can understand that a baby's body is built from the foods the mother eats. They can also understand the relationship of certain nutrients to certain phases of the baby's physical development. In our experience very few of them want to explore the mechanisms by which this happens.

When teaching serving sizes, it is best to show them samples or pictures rather than to discuss the concept in ounces. We have found that the more concrete the teaching, the more likely students are to absorb it.

Approach the study from the perspective of the students' motivations. The pregnant teenager is a teenager who is also pregnant. Her concerns are still very much like those of other adolescents. She is concerned about her own well-being, her health, and her looks. She is probably anxious about labor, delivery, and recovery. She may also be concerned for her unborn baby but is not *always!* Your instruction in nutrition will be most effective when you approach it from the point of view of your students' motivations.

Utilize visual aids. The visual aids that you use should be appropriate to the level of your students. They should be simple to understand. Be sure that your visual aids include the foods your students are accustomed to eating.

Integrate experiential activities whenever possible. The study of nutrition is greatly enhanced by activities that provide the students with the opportunity to apply their learning. The degree to which you can incorporate experiential activities will depend upon the setting in which you work.

Many activities can be done individually and in groups. Your students can be taught to read labels, compare prices, and compare quality of foods. They can learn a great deal from visiting stores to explore methods of propaganda and store layout and to do some comparison shopping. When facilities are available, students will enjoy preparing foods from the various food groups. Pregnant teenagers can also benefit from learning to prepare nutritious snacks. These activities are excellent means by which to reinforce learning. You are encouraged to expand upon concepts related to meal planning and preparation as well as to consumer buying whenever possible.

Individual interviews. Ideally the young woman should see a trained nutritionist throughout her pregnancy. We understand that such a service is not always available. Whenever possible a minimum of two individual interviews devoted to nutrition are recommended. Depending upon your own training in nutrition, you may be called upon to work individually with the young woman to help her with her eating habits. This approach is good because it enables you to discuss privately her living situation, attitudes toward food, economic factors, and other motivations. Individual interviews provide an excellent opportunity to individualize your teaching.

A diet record may be very helpful for this purpose. Ask the young woman to keep a list of *everything* she eats for two or three days. When she completes the record, you can discuss it with her, indicating good points as well as areas needing more attention. Explore ways by which she can supplement the areas that are lacking. Be sure these explorations take into consideration her preferences and limitations in obtaining foods.

An untrained person should never attempt to counsel a young woman regarding dietary restrictions. Such counseling should always be left up to the health care provider. This person will be able to assess the specific needs of the young woman and to determine appropriate dietary alterations.

There is some disagreement among health care providers as to the use of salt during pregnancy. The current position of the American College of Obstetricians and Gynecologists is as follows:

> The practice of routinely restricting salt intake, and at the same time prescribing diuretics without clinical indicators, is of doubtful value and is potentially dangerous. The use of iodized salt should be encouraged unless contraindicated.
>
> ("Adolescent Perinatal Health: A Guidebook for Services," ACOG 1979, p. 29)

We recommend this organization as a resource for further information regarding nutritional risks and assessment of maternal nutrition. The New Mexico State Health Department has a Nutrition Unit that is another valuable source of materials and information. We suggest that you check to see if such a resource is available in your own state.

I. Chapter Goals

- A. To teach the nutritional needs of the pregnant teenager, emphasizing the benefits of good nutrition for both mother and child
- B. To describe the requirements for a well-balanced diet for the pregnant adolescent
- C. To motivate the young mother to practice good eating habits

II. Important Concepts

- A. The well-being of the developing fetus is dependent to a large extent upon the nutritional status of the mother.
- B. Nutritional status is one of the primary factors affecting maternal health and recovery following delivery.
- C. The pregnant teenager needs to be especially careful to eat a good diet because her own body is still growing, because she may be in poor nutritional health at the beginning of pregnancy, and because she has an increased risk of premature delivery or delivery of a low birthweight baby.

III. Learning Objectives

The student will be able to do the following:

- A. List four reasons why a good prenatal diet is beneficial to the pregnant teenager;
- B. List four reasons why a good prenatal diet is important for the baby;
- C. List the number and size of servings of milk and milk products, meat and other protein foods, fruits and vegetables, breads and cereals, and water needed by a pregnant teenager;
- D. List good food sources of iron, protein, calcium, folic acid, and vitamin C;
- E. Explain the importance of calcium, iron, protein, and folic acid in pregnancy;
- F. Plan a well-balanced diet for one day, incorporating her own food preferences.

IV. Content Overview

Text Page

- A. Importance of good nutrition. 34, 35
  - 1. Food for growth
  - 2. Benefits to mother
  - 3. Benefits to baby
  - 4. Frequently asked questions related to prenatal nutrition
- B. Nutritional needs of the pregnant adolescent. 36, 37
  - 1. Milk and milk products
    - a. Four to five servings daily
    - b. Sources of calcium, protein, vitamin D, and vitamin A
  - 2. Meat and other protein foods
    - a. Three or more servings daily
    - b. Sources of protein, iron, folic acid, and B vitamins
    - c. Vegetable protein
      - 1) Is more readily utilized by the body when accompanied by a small amount of animal protein such as milk or cheese (examples: pinto beans with cheese, black-eyed peas with ham hocks, etc.)
      - 2) Is less expensive and makes a valuable contribution to dietary intake
  - 3. Fruits and vegetables
    - a. Four to five servings daily
    - b. Vitamin C, at least one serving daily
    - c. Vitamin A, at least one serving daily
  - 4. Breads and cereals
    - a. Five to six servings daily
    - b. Sources of B vitamins and iron if whole grain or "enriched"
  - 5. Water
    - a. Six to eight (8-oz.) glasses daily
    - b. Provides body fluids needed for waste elimination, increased blood supply, added tissues, and absorption of nutrients.
- C. Vitamins and minerals essential for body growth and repair. 36, 37
  - 1. Calcium for bones, teeth, nerves, and muscles
  - 2. Vitamin D for utilization of calcium and prevention of rickets
  - 3. Vitamin A for eyes, skin, hair, and normal body growth
  - 4. Vitamin C for general resistance to infection and for teeth, gums, bones, body cells, and blood vessels
  - 5. B vitamins for nerves, appetite, and utilization of other nutrients
  - 6. Folic acid for absorption of iron
  - 7. Iron for production of red blood cells and prevention of anemia, stored in fetus' body during last months of pregnancy
  - 8. Protein for building and repair of body tissues, brain, and blood
- D. Supplemental charts. 38, 39
  - 1. "You and the Baby Are What You Eat!"
  - 2. "Special Food Tips for Pregnancy"

V. Suggested Learning Activities

- A. View films on normal nutrition and nutrition in pregnancy, and follow with a discussion of the importance of good nutrition.
- B. Solve this problem:
  Polly is pregnant and doesn't like milk. Think of four ways she can make sure she still gets enough of this food group in her diet.
- C. Make two lists of snacks. On the left include snacks that are nutritious. On the right include snacks that have only "empty calories" and no nutritional value. To decide if a snack is nutritious, refer to the food chart in the book.
- D. Write a letter giving a teenager advice about her eating habits during pregnancy. Tell her why she should follow your advice.
- E. Plan well-balanced meals using foods from the various cultural groups.
- F. View and discuss films on consumer buying tips.
- G. Invite a nutritionist to talk about Food Stamps, W.I.C., and other food programs.
- H. Discuss or answer in writing the questions in part VI.

VI. Questions for Discussion/Study Guide

- A. Why is it especially important for a pregnant teenager to eat well?
- B. List four ways that eating well during pregnancy helps the mother.
- C. List four ways that eating well helps the baby.

D. Fill in the following chart:

Nutrient	What Does It Do?	What Foods Can You Get It From?
Protein		
B Vitamins		
Vitamin A		
Vitamin C		
Vitamin D		
Calcium		
Iron		
Folic Acid		

E. Keep a record of everything you eat for one full day.

Breakfast:

Snacks:

Lunch:

Snacks:

Dinner:

Snacks:

F. Decide which food group each food you ate belongs in. Count up the total number of servings in each group.

Fill in the following chart:

	How Many I Had	How Many I Need	What I Could Add to Make It Complete
Milk and Milk Products			
Meat and Other Protein Foods			
Fruit and Vegetables			
Bread and Cereals			
Water and Other Fluids			

G. Plan a day's meals for a pregnant teenager. Be sure she gets everything she needs. Use only the foods you like to eat!

Breakfast:

Snacks:

Lunch:

Snacks:

Dinner:

Snacks:

VII. Resource Materials
- A. Films:
  1. *Eat, Drink, and Be Wary*
  2. *Great Expectations*
  3. *Nutrition: The Inner Environment*
  4. *Super Goop*
- B. Filmstrip/Cassette: "Inside My Mom"
- C. Charts:
  1. "Basic Four" food charts, food models, food comparison cards, National Dairy Council
  2. "Nutrition Information Cards," March of Dimes PEP
- D. Pamphlets:
  1. *Adolescent Perinatal Health: A Guidebook for Services* (professional), American College of Obstetricians and Gynecologists
  2. *Assessment of Maternal Nutrition* (professional), American College of Obstetricians and Gynecologists
  3. *Food and You — Partners in Growth During Pregnancy*, National Dairy Council
  4. *Food for the Teenager During Pregnancy*, DHEW Pub. No. 77-5106, 1977
  5. *Food for Thought and Eating* March of Dimes PEP
  6. *A Guide to Good Eating*, National Dairy Council
  7. *Junk Food Blues*, March of Dimes PEP
  8. *Nutrition and Pregnancy*, March of Dimes
- E. Books:
  1. *The Mother's Cook and Cope Book*, Lane and Zapata
  2. *Nourishing Your Unborn Child*, Williams
  3. *The Pregnant Cook's Book*, Lane and Zapata

Chapter Eight

"MAKING DECISIONS FOR YOU AND YOUR BABY"

Pages 40-52

About the Chapter

Helping Teenagers Make Decisions

The pregnant adolescent must make decisions on a number of issues, decisions that affect her future and that of her child. Issues demanding decisions range from health to education, from preparing for self-sufficiency to arranging for living situations. It is safe to say that if you work with pregnant teens, you will be involved in some way in helping them with the decision-making process.

Regardless of the exact nature of the situation with which the young person is dealing, it is your responsibility as a helping person to facilitate the decision-making process. *It is not your responsibility to arrive at a solution to the problem situation!* In the student text we have offered a simplified model of the decision-making process. Many young people are inexperienced in making their own decisions. They may need your assistance in applying this process to solving their problems.

An important preliminary step is the clarification of the problem situation. The young person may not have formulated a clear idea of exactly what the problem really is, particularly if there are many outside pressures and internal upheavals accompanying the situation. You can assist the young person with organizing her thoughts and feelings so that she can become clear about the exact nature of her problem situation.

To be of assistance it is vital that you become a good listener. The person who is able to listen effectively is able to give *full* attention to the speaker. There are several things you can do to check yourself on your listening skills.

First, notice your body language. A relaxed posture accompanied by frequent eye contact will indicate to the young person that you are "with" her. Such body language as nervous movements, gazing around the room, tapping fingers on the table, or shuffling papers are indications of lack of attention.

Next, notice your thought processes as you listen. When you are listening attentively, you will probably be relatively unaware of anything other than the message being conveyed by the person speaking. If you find your mind wandering or if you are busily engaged with formulating your own reply, you are not really receiving the communication.

Finally, notice your general responses during the communication. A person who is listening carefully may nod his head or make occasional sounds to indicate understanding. If you are preoccupied with time, you may find yourself frequently looking at the clock. Another sign of inattentiveness is interrupting the speaker to get your own point across.

Some young people have an easier time with verbal communication than others. You can facilitate the interaction by asking questions that assist them in formulating their thoughts. Keep in mind, though, that the ultimate purpose of such questioning is clarification for the young person. Many young women report that they feel they are being interrogated when asked too many very personal questions. The type of questions you ask should depend upon the rapport you have established, upon the nature of the problem, and upon other factors which vary from situation to situation.

Before proceeding into the steps of the decision-making process, you can be helpful by repeating back to the young person exactly what you have heard. Repeating serves several functions. First, it confirms to both of you that the communication has been received. Next, repeating provides the opportunity for any miscommunications to be cleared. Finally, the young person has the opportunity to listen to a statement of her own problem situation. When the problem has been clarified and defined, you can proceed to help the young person apply the steps of the decision-making processes.

Facilitating the Use of the Decision-Making Model

Step One — Gathering Relevant Data

Very often young people attempt to make decisions based on incomplete or hypothetical information. For example, they may formulate hypotheses about what parents or friends expect from them without ever having verified these hypotheses. Young people may also assume that they can get high-paying jobs without ever having ascertained the level of education that may be required for such positions.

Your role in the fact-finding step is to help the young person in her accumulation of relevant data. You may help her determine what information she needs, refer her to appropriate information sources, or suggest that she confirm her hypothesis with people involved. It is important that she confirm her hypotheses herself, however, and that you do not do this for her. The young person needs to gain experience and confidence in laying the groundwork for making a decision.

Step Two — Listing the Choices

A young person may not be aware of the options that are available to her. Initially, she may feel that she has no choice at all, or she may see only one solution to her problem. You can assist the young person to formulate a number of possible solutions. It may be reassuring to her to discover that there are several avenues open to her, even if they may not all appear appropriate at the outset. On the other hand, some young women do not have a wide variety of choices at certain times in their lives. They need help in identifying and sorting through the choices they *do* have.

Steps Three and Four — Evaluating the Choices

The purpose of these two steps is clarification of the options. The young person needs to evaluate each possible choice *realistically.* Teenagers often are inexperienced and may need a great deal of help with realistic evaluation. You can facilitate this process by helping them project possible consequences related to each of the alternatives. For example, a young person who has been financially dependent upon parents may find it difficult to evaluate realistically the alternative of living on welfare. To such a person, a monthly check may seem like quite a lot of money. She may equate welfare allotments with the purchase of a new car or with a life in a lovely apartment. This young person will need your help in realistically evaluating the costs of food, clothing, rent, utilities, and other necessities. We recommend that such explorations be done in a supportive and gentle manner. If you come on too strong, you may be interpreted as a know-it-all adult who is trying to tear down her dreams.

Since many teenagers are still dependent upon their families, the needs and feelings of family members may be of particular importance in the evaluation of options. It is of absolute importance that a young woman learn all she can about her family's attitudes and their willingness to support her plans. This knowledge is especially necessary if she plans to continue living at home, to remain financially dependent, or to depend upon family members for child care! On the other hand, the older teen may have more options available to her if she has completed high school, is employed, or lives on her own.

Step Five — Selection of an Alternative

Once the young woman has evaluated each of her options, she is in a position to make a final choice. The length of time it takes to arrive at this point may vary considerably according to the nature of the decision to be made as well as to other related factors. Whenever possible, it is best to allow the individual as much time as she needs. When there *are* time limitations involved, these limitations should be discussed as early in the decision-making process as possible.

Arriving at a decision involves far more than the intellectual evaluation of alternatives. The feelings and emotions of the young woman, as well as of those close to her, will usually have a significant effect. It will be important that you empathize with the feelings of those involved and recognize that intense emotions will strongly affect the decision-making process.

Above all, avoid telling the young person what to do! There will be times when you have strong feelings or opinions about the situation. You may find it very difficult to remain objective and to avoid involving yourself in her decision. Keep in mind, though, that the decision must come from those whose lives are involved. It is the young woman, and perhaps those close to her, who will

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live with the consequences of the decision.

Step Six — Accepting the Choice and Living with the Consequences

There is a strong indication that it is easier for people to accept the consequences of choices they feel they have made for themselves than it is to accept the consequences of choices made for them. That statement does not imply that they will never experience doubt or frustration with the consequences. Once a young person has made and carried out her decision, she may continue to need the same sort of support you gave her prior to making the final decision. If possible, continue to make yourself available to her if she desires contact in the future.

Susan Jones, one of the teachers at New Futures School, succinctly summarized the role of the helping person in decision making:

> Respect their decisions, both personal and academic. Guidance in decision making seems to be best when it helps a girl make a choice she can feel good about or underscores the positive aspects of a choice she's made.

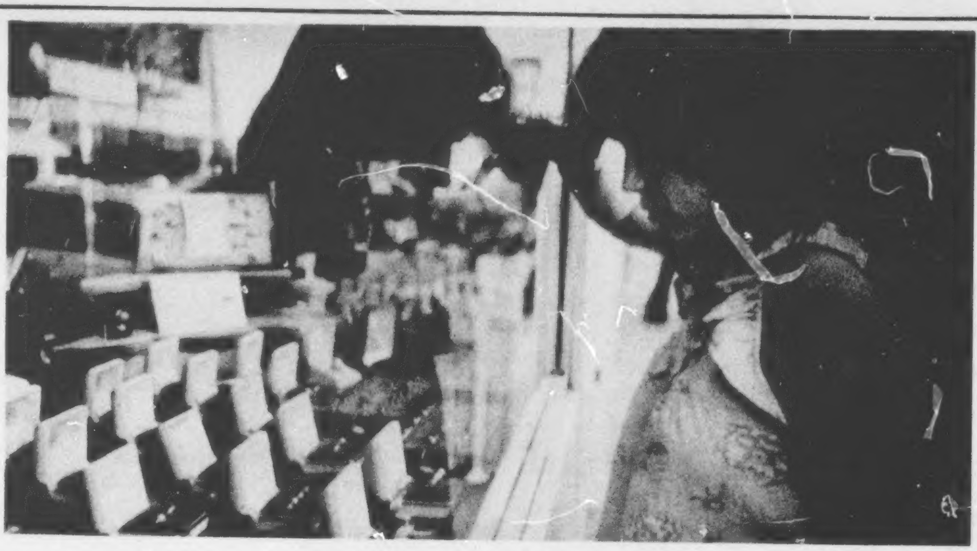
Step Seven — Re-Evaluating Decisions

It is important to remember that many of the young people with whom you are working find themselves in very unstable environments. A set of circumstances that influenced decision making yesterday may be radically different today and may be changed again by next week. Decisions may have to be altered as circumstances change. New factors must be analyzed and weighed, implying that you, as a helping person, need to remain in regular contact with your clients regarding their decisions.

Exploring Pregnancy-Related Alternatives

To a large extent the content of this chapter is directed specifically to the decision-making process as it relates to choices pregnant adolescents must make. These decisions may be some of the most difficult a young woman will ever face. We have included questions the young woman can ask herself about some of the most commonly considered options: keeping the baby, releasing it for adoption, getting married, and/or remaining single. These questions are designed to stimulate thought and to help the young woman evaluate each of the options more realistically.

Those of us who work with pregnant teenagers are aware of the lack of realism that many young women demonstrate when making their choices from among these options. This apparent lack of realism is due in part to inexperience. In addition, teenagers' thought processes often operate on a concrete level; and they may find it difficult to think on an abstract level. Their orientation to the present may interfere with their ability to project into the future and to be able to evaluate possible consequences and outcomes.



When assisting pregnant teens to explore the alternatives available to them, it is especially important that you attempt to remain objective. Objectivity may be extremely difficult at times. For example, a young woman's home situation may appear to be particularly negative, and you may have strong feelings that it is not a good environment in which to rear a child. Or you may have serious doubts as to whether or not a young woman will be a competent parent. There are no easy solutions to such dilemmas. In these cases, as in all others, it is your role to help those involved to evaluate realistically the consequences of their final decisions. Keep in mind that the final decisions must be theirs, and be willing to support and respect their choices.

Peer pressure may be a factor that significantly affects a young woman's decision. As mentioned earlier, a very high percentage of young women elect to keep their babies. Peers may put pressure on the young woman who is considering releasing for adoption. Those who are keeping are likely to question the motivations and the character of one who is releasing. Under such pressure only a very strong, self-directed person can make the decision to release and then carry through with it. We feel strongly that young women need help in respecting one another's rights to make their own decisions. We place a strong emphasis on the fact that everyone's situation is different and, therefore, that the same decision is not right for everyone.

Many young women believe that marriage will be the answer to all of their problems. Married teens may perpetuate this myth by displaying their wedding rings with an air of superiority. They often hide their marital difficulties and pressures from the others in an effort to maintain the image. Because of the facade, young women are often surprised to learn that a married friend is facing a divorce.

We have mentioned only briefly the option of abortion in our student text. By the time they enter a program for adolescent parents, most young women have made the decision to carry their pregnancies to term. Abortion is a very controversial subject in our nation. For these reasons we have left to your discretion the extent to which you want to discuss this alternative with a young woman. If you choose to explore the option of abortion, keep in mind that a teenager may not have fully clarified her values related to the issues of life and death. Also keep in mind that the young woman may have a desire to delay making a decision. Childbirth may be viewed as something nebulous or in the far distant future. Abortion, on the other hand, would be an experience to be faced in the present. All of these factors may significantly influence the young woman's perception of the abortion issue.

The original version of the student text did not include the case studies of the six former students. These studies were added upon request from the pregnant students who field-tested our book. It was their opinion that such stories would give a more realistic view of the future consequenses related to each of the options. We recommend that these case studies be used as a basis for discussion. It should be stressed that the exact outcome of any one of the various choices will be unique for each individual. The point can be made that, regardless of the choice, life does go on and adjustments can be made. The happiness and success that result will depend upon the individual's own orientation to life and upon her own degree of determination.

I. Chapter Goals
- A. To encourage self-awareness and self-understanding as a basis for sound decision making
- B. To assist in the exploration of choices related to teenage pregnancy
- C. To present the steps in the decision-making process

II. Important Concepts
- A. No one decision is right for everyone because each individual's circumstances are different.
- B. Decision making is facilitated by self-exploration and gathering of information.
- C. Decision making is both a cognitive and and affective process.
- D. Making decisions is facilitated by following the orderly steps in the problem-solving process.

III. Learning Objectives

The student will be able to do the following:
- A. List the pros and the cons of at least two of the alternatives available to the pregnant adolescent;
- B. Use the steps in the problem-solving process by applying them to a problem situation of her choice.

IV. Content Overview

	Text Page
A. Exploring choices related to adolescent pregnancy	41-45
1. Keeping versus releasing the baby	
a. Demands of parenthood	
b. Personal goals	
c. Planning for a baby	
d. Reactions to releasing a baby for adoption	
e. Reactions of significant others	
2. Questions and concerns related to teenage parenthood	
a. "Trying on" the idea of parenthood	
b. Preservation of personal identity	
c. Involvement of grandparents	
d. Single parenthood	
e. Social life	
3. Questions and concerns related to adoption	
4. Marriage versus single parenthood	
a. Readiness for marriage	
b. Relationship between partners	
c. Personal values and goals	
d. "Trying on" the role of wife	
5. Abortion	
B. Problem-solving process	46
1. Gathering information	
2. Listing alternatives	
3. Evaluating the advantages	
4. Evaluating the disadvantages	
5. Making a choice	
6. Living peacefully with your choice	
C. Case studies	46-52

V. Suggested Learning Activities
- A. View films related to teenage pregnancy, parenthood, and decision making.
- B. Define a problem, and list options under each of these headings:
  1. What my family wants me to do
  2. What my boyfriend wants me to do
  3. What my friends want me to do
  4. What I want to do

  Discuss difficulties related to pleasing everyone.
- C. Interview single mothers (or have a panel) to learn about their experiences.
- D. Invite someone who has released a baby for adoption and/or an adoptive parent to discuss their feelings and experiences.
- E. Write a personal want ad for "your perfect mate." Each ad should be done individually and anonymously. In the classroom setting the ads may be utilized to lead group discussion. Differences in preferences should be treated with respect.
- F. Interview two married couples, preferably one older couple and one younger couple. Find out about the roles the partners play in the marriage, parenthood, etc. Discuss the differences and the similarities.
- G. Play the game called "Wheel of Fortune" to help students learn to make choices related to life goals.
- H. Discuss the steps in the decision-making process. Show how the principles work by applying them to a sample problem such as making a decision about marriage, making career choices, etc.
- I. Discuss or answer in writing the questions in part VI.

VI. Questions for Discussion/Study Guide

A. Mary is 16 years old and pregnant. She is in the 11th grade and lives at home with her parents. Her parents want her to release her baby for adoption. Her boyfriend is also 16. He wants to run away and get married. Mary doesn't know what she wants to do. List the advantages and disadvantages of keeping her baby, releasing it for adoption, and getting married.

B. When you are trying to solve a problem, it helps to use the steps listed on page 45 in making a decision. Choose a problem that you would like to solve, and answer the following questions:

1. What is the problem?
2. What kind of information do you have or need to solve this problem? Where can you get the information you need?
3. Fill in the following information:

My choices are:	*Things I like:*	*Things I don't like:*

4. Which choice seems to fit you best? Why?
5. Can you be happy with this choice?

VII. Resource Materials

A. Films:
   1. *Growing Up Together*
   2. *I'm Seventeen and Pregnant*
   3. *Teenage Father*
   4. *Woman-Child*
   5. *Young, Single, and Pregnant*

B. Slide/tape: "I'm Not Bad, Just Pregnant"

C. Game: "Wheel of Fortune"

D. Pamphlet: *Am I Parent Material?* National Organization for Non-Parents

E. Books:
   1. *Coping With School Age Motherhood,* Walsworth and Bradley
   2. *Only Human,* Howard
   3. *Parenting: A Guide for Young People* (pp. 5-27), Gordon and Wollin
   4. *Pregnant Too Soon: Adoption Is an Option,* Lindsay

"The simplest questions are the most profound.
Where were you born?
Where is your home?
Where are you going?
What are you doing?
Think about these once in awhile, and watch your answers change."

"Every person, all the events of your life are there because you have drawn them there. What you choose to do with them is up to you."

— Richard Bach
Illusions

Chapter Nine

"WHAT TO EXPECT IN THE HOSPITAL"

Pages 53-59

About the Chapter

Overview

Chapters Nine, Ten, and Eleven in the student text are interrelated, each dealing with a different aspect of the childbirth experience. While it is true that the actual labor and delivery process takes place in the shortest time span of the whole childbearing period, the subject cannot be "glossed over" lightly in a single teaching session. You will probably find that young women show more interest in this topic than in any other you may be teaching!

We have found that there seems to be a mystical shroud that surrounds the whole experience of childbirth in the minds of many young women. Most women who have had babies love to describe in vivid (and perhaps gory) detail what their labor and delivery experiences were like. You can be sure that every young woman has heard *something* about labor, and what she has heard is not always accurate or comforting! Consequently, you will find that fears, questions, and concerns regarding childbirth occupy the minds of pregnant adolescents during most of their pregnancies and are frequently expressed in your encounters with them.

Many of their questions and concerns indicate a fear of the unknown. "What does a contraction feel like?" "How will I know for sure that I am in labor?" "How long will my labor last?" "Why do they use so many needles?" "What if I can't stand the pain?" "Will I die?" "Will my baby be all right?" These are questions we hear over and over. Many of them are difficult to answer. No two women experience labor in the same way. The way in which a young woman goes through childbirth and the way in which she copes with the discomfort are dependent upon many factors. We cannot overemphasize the importance of her preparation for this event. The gaining of knowledge, the dispelling of fears, and the physical training through exercises and special breathing techniques all serve to enhance the potential for a rewarding childbirth experience. The young woman's maturity level, physical status, and pain threshhold also play a role in her reaction to labor and delivery. You have both a tremendous challenge and an opportunity in being the helping person who facilitates the process of making childbirth a truly rewarding experience. It can be very gratifying to have a young woman tell you after she has had her baby that what she learned from you made the whole experience seem easy!

Teaching Labor and Delivery

In the student text we discussed what a young woman can expect to happen during her hospital stay before we discussed the physiology of the labor and delivery process. There are two schools of thought about which should be taught first. We have found that most young women are more concerned about what is going to happen to them during labor and delivery than they are about the actual physiology of the process. An understanding of the process, however, enables them to understand better what is happening to them. You may want to have them read all three chapters at the same time before you begin any discussion of the subject. Your discussions can then be based upon their questions and concerns.

There is definitely a medical orientation in the way we presented the topic. We are aware of the trend in today's society away from the traditional hospital delivery. Alternative birth centers and "birthing rooms" in hospitals are being developed around the United States. There is a trend toward a more family-centered approach and even toward home deliveries. The alternatives to the more traditional hospital delivery, however, are not options open to all women. Though there is much to be said in favor of these alternatives, many health care providers recommend a hospital delivery for pregnant adolescents. The hospital approach we used is the one most currently being selected by/for our pregnant teen population. We suggest that you familiarize yourself with the options available in your community and invite qualified speakers to discuss the alternative methods of delivery that may be appropriate for your students.

In Chapter Nine, "What to Expect in the Hospital," we have taken the reader on a "guided tour" of the more common hospital procedures. In the field-test version of the student text, we used illustrations to depict the various areas and procedures used during the labor and delivery experience. We learned that the young women wanted "real" pictures instead of drawings to help them better understand what would be happening. The general consensus seemed to be that the more they could know about the "real" experience, the less frightening it would be. You may find that the hospitals or childbirth education classes in your area have developed slide presentations that explain the various procedures. We encourage you to use them if you can. Slides give you the opportunity to discuss important points and to alleviate fears about what the students are seeing.

Taking a tour of the hospital facilities is another excellent method of helping young women to become familiar with what they can expect. Don't be surprised if your students seem quite disinterested while in the delivery room. A follow-up discussion of what they saw and the feelings they experienced will usually tell you that they comprehended more than you thought! Reassurance that all of the equipment that they saw is not used during every delivery can help to alleviate fear.

Another effective method of teaching labor and delivery is the use of guest speakers. A carefully selected maternity nurse from a local hospital can often answer specific questions that arise. Because she actually works in the maternity area, the nurse can lend credibility, reinforcing what you are teaching. It can be very reassuring to young women to hear and see a person who might be taking care of them in the hospital.

The use of childbirth films is controversial. Films which focus only on the delivery of the baby can be frightening and/or even embarrassing to pregnant teens. The exposure of the perineum with its episiotomy and blood may increase the fear and dread that some young women experience. Many films are couple-oriented, projecting the message "You'll never make it without your husband's presence." For obvious reasons these films are unsuitable for use with young, single women. Fortunately, there are many new, good films available that can be used successfully in class. We have listed the ones we think are the most useful for pregnant adolescents. We do suggest, however, that you first preview any film on labor and delivery that you plan to use. You may decide that some films are best used at the end of your childbirth unit when your students are familiar with what to expect.

Specific Concerns in "What to Expect in the Hospital"

There are certain hospital procedures that seem to cause fear, embarrassment, or concern for young women. Preps and enemas, although not universally given, are two examples. Both procedures involve very personal and private parts of the body. Many women do feel some embarrassment and do not particularly like to have preps or enemas. It may be helpful to explain the reasons for these procedures.

The I.V. is another procedure that causes concern. Many young women express fears related to the use of needles. You can explain that the I.V. feels like a shot given one time and does not cause continual pain the entire time it is in place. Movement should not be hampered significantly with an I.V., and walking may be allowed. Some health care providers allow the patient to drink small amounts of water and juice during labor; but, generally speaking, intake of fluids and food will be restricted.

Fetal monitors are being used more and more in hospitals today. The monitoring machine records on graph paper the fetal heart rate and the intensity and timing of contractions. There may be an audible beeping as the heart rate is recorded. There are two methods of fetal monitoring, external and internal. The external monitor has two straps that are placed on the abdomen with electrodes leading to a machine that records the data. The internal monitor has an electrode that passes through the vagina and cervix and

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attaches to the baby's head. Also a small tube (catheter) is passed through the cervix to record uterine contractions. Internal monitoring can be used only after the bag of water has ruptured. Both types do limit movement somewhat but should not be painful. Since fetal monitors are being routinely used in many hospitals, you can reassure students that this does not indicate that problems are suspected. Young women may find it interesting to observe the baby's heart rate and the uterine contractions on the monitor.

Episiotomies are routinely done on most women having their first child. This procedure is another that can be scary for many adolescents. If young women understand why episiotomies are necessary and that pain should not be experienced when the incision is made, then many of their fears can be alleviated. Many report that their episiotomies were not nearly as bad as they had dreaded! The discomfort of the episiotomy can be lessened by taking sitz baths and/or by focusing a heat lamp on the perineal area. A young woman may be hesitant to take sitz baths unless she understands the great comfort they offer.

There may be some discomfort experienced during the massage of the uterus after delivery. Self-massage should be taught as it is more comfortable than a massage by an over-zealous nurse! This procedure is necessary to prevent hemorrhage by keeping the uterus contracted.

In the chapter "Teenagers as Parents," we discussed maternal-infant attachment. Many researchers place a great deal of emphasis on the importance of close contact between mother and child in the early hours and days following birth. Although the quality of the bond between mother and infant in their future relationship is not *totally* dependent on this early contact, interaction and physical contact will help mother and child to get acquainted with one another. The young mother has the right to *ask* to see and hold her baby in the delivery room. She can also ask to breastfeed her baby immediately after birth if she desires. Fortunately, many delivery room personnel recognize the importance of early contact and grant the mother's wishes if the baby is in satisfactory condition.

Most hospitals now allow the fathers of the babies to be present in the labor room. Many also allow them to be present for the actual birth. As with the mother, it is believed that early, close contact between the father and his child greatly facilitates the formation of a bond between the two. In the student text we have not stressed the importance of the father's presence during the labor and delivery experience because many young women are without male partners. Expectant parents should be encouraged to discuss with their health care providers their desires for early parent-infant contact. Discussions can help to alleviate their anger or disappointment if their expectations cannot be met.

If you are a nurse caring for a pregnant adolescent during her labor and delivery, keep in mind that this may be her first hospitalization experience. She may be frightened not only of labor but also of the strangeness of the hospital setting. The nurse who is warm and caring and who listens with concern can be very helpful in alleviating the fears of a frightened young woman. Remember the patient's fears regarding procedures, needles, and machinery, and explain their uses. Minimize vaginal exams and undue exposure of the perineum as these procedures are embarrassing to the adolescent. She will need the tender, loving care you can give; but she also needs for you to be firm in your requests, providing her with guidelines as to what to do. She will respect you for helping her maintain control.

As noted above, each pregnant woman approaches the process of labor and delivery with some fear and apprehension. One fear each woman has about labor and delivery is that she will not perform well. Each patient should be told that she performed well even though she may have lost control. Positive statements by the medical staff will enhance her self-respect.

Following delivery, you can help the mother and her infant interact to facilitate bonding. Encourage her to examine her infant. Everything possible should be done to assist the mother and her child to have a positive first meeting. Be alert to any negative reactions the mother may have to her newborn at the time of delivery. These early responses can be indicative of a need for intervention and follow-up.

Mothers who plan to release for adoption have differing individual needs concerning the amount of interaction that is desired with the newborn. The trend seems to be that most relinquishing mothers want to see their babies after birth. Seeing the baby may indeed help a relinquishing mother to face the reality of her pregnancy and to facilitate the grieving process. Research is scanty on this issue, however; and we recommend that the needs of the young woman be recognized and that the decision of whether or not to see the child be her own.

I. Chapter Goals

- A. To reduce fear and to develop confidence by becoming familiar with what can be expected during the hospital experience
- B. To stress the importance of mother-infant interaction during the hospital stay as a basis for developing a strong parent-child relationship

II. Important Concepts

- A. The quality of the hospital experience can be favorably influenced by a knowledge of hospital procedures and policies.
- B. The quality of maternal-infant bonding in the immediate postpartum period may have a profound effect on the future relationship of mother and child.

III. Learning Objectives

The student will be able to do the following:

- A. Describe when the woman in labor should go to the hospital, where she should first go, and what she should take with her;
- B. Explain what a prep and enema are and why each is done in preparation for delivery;
- C. Explain why the woman in labor should not eat a large meal;
- D. Explain how the mother is assured of adequate fluid intake during labor and delivery, even though hospital routine usually does not allow her to eat or drink during labor;
- E. Explain what the episiotomy is and why it may be done;
- F. Describe the care given to the newborn in the delivery room;
- G. Define *forceps, birth certificate,* and *circumcision;*
- H. Describe the procedures needed during the first hour after delivery, and be able to explain the purpose and importance of the massage of the uterus.

IV. Content Overview

Text Page

- A. When to go to the hospital 53
- B. Where to go 53
- C. What to take 53
- D. Hospital procedures and care 54-59
  - 1. Admission
    - a. Preliminary examination
    - b. Prep
    - c. Enema
  - 2. Labor room
    - a. Restricted food and liquid intake
    - b. I.V.
    - c. Vaginal examinations
    - d. Breaking of bag of water
    - e. Visitors
    - f. Fetal monitor
  - 3. Delivery room
    - a. Preparation for delivery
    - b. Equipment
    - c. Episiotomy
    - d. Mother-infant contact
    - e. Placenta
  - 4. Care of the baby
    - a. Identification bands
    - b. Krieselman (warmer)
    - c. Initial exam
    - d. Weight and measurement
    - e. Eyedrops to prevent gonorrhea infection (silver nitrate or penicillin)
    - f. Suctioning of mucus from nose and throat
    - g. Clamping of cord
  - 5. Recovery room
    - a. Importance of care during the first hour

        b. Blood pressure
        c. Pulse
        d. Massage of uterus for control of bleeding
        e. Pads checked for amount of bleeding
        f. Ice pack for stitches
        g. Food, if desired
    6. Postpartum stay
        a. One to three days
        b. Walking with assistance
        c. Showers
        d. Sitz bath
        e. Baby-care classes
        f. Visitors
        g. Exercise (see Exercise Booklet)
        h. Mother-infant interaction
        i. The mother who releases
    7. Birth certificate
        a. Legal requirement
        b. Importance of obtaining a copy
    8. Circumcision
        a. Surgical removal of foreskin
        b. Preferences closely related to familial, religious, and cultural background
        c. Procedure no longer considered medically necessary

V. Suggested Learning Activities
    A. View film on the labor and delivery experience in the hospital. It is best to use a film that emphasizes the hospital care rather than the delivery experience.
    B. Discuss with doctor or midwife the type of mother-infant interaction that is allowed following delivery and why.
    C. View film or slides on parent-infant interaction following delivery and discuss why this interaction is important.
    D. Have a certified nurse-midwife and/or *partera* discuss how a homebirth or maternity center experience is different from a hospital delivery.
    E. Tour the labor and delivery facilities of a local hospital.
    F. Invite a labor and delivery room nurse to talk to the students and to answer questions.
    G. Discuss or answer in writing the questions in part VI.

VI. Questions for Discussion/Study Guide
    A. When do you go to the hospital in labor? Where should you go? What should you take?
    B. What is a prep? Why is it done?
    C. What is an enema? Why is it done?
    D. Why *shouldn't* you eat a large meal when you are in labor?
    E. How does the doctor make sure you get enough fluids?
    F. What is the episiotomy? Why is it done?
    G. What kind of care does the new baby get in the delivery room?
    H. What will the nurses do for you during the first hour after delivery?
    Why will they massage (rub) your uterus?
    I. What is a sitz bath? Why should you take sitz baths?
    J. If a mother is planning to keep her baby, why is it important for her to spend time with the baby during the hospital stay?
    K. Define:
        1. Forceps
        2. Birth certificate
        3. Circumcision
    L. Are there things about the hospital stay that scare you? Explain. From whom could you get more information about the things you fear?

VII. Resource Materials
    A. Films:
        1. *A Child Is Born*
        2. *The Bonding Birth Experience*
        3. *Lynn and Smitty*
    B. Slides/Cassettes:
        1. *Birth and Bonding*
        2. *The Nurturing Father*
    C. Books:
        1. *Birth*, Meltzer
        2. *Childbirth Without Fear*, Read
        3. *Choices in Childbirth, Feldman*
        4. *Cuidado Prenatal y Preparacion para el Parto*, Richards
        5. *Husband-Coached Childbirth*, Bradley
        6. *Maternal-Infant Bonding*, Klaus
        7. *New Miracles in Childbirth*, McCleary
        8. *Preparation for Childbirth*, Ewy
        9. *Teenage Handbook for Prepared Childbirth*, Bradley
        10. *Teenage Parents*, Edwards
        11. *Thank You, Dr. Lamaze*, Kormel
    D. Articles:
        1. "Adolescent Pregnancy," notes from a seminar sponsored by NAACOG; Catalano and Corbett
        2. "Peer Group Instruction for Primigravid Adolescents," Barnard

Chapter Ten
"BEING COMFORTABLE DURING LABOR"
Pages 60-63

About the Chapter

The focus of this chapter is on comfort measures that will make the childbirth experience easier. Refer to Chapter Nine for a more detailed discussion of teaching methods that can be useful in teaching the three-chapter unit on labor and delivery.

It is our belief that when a woman is fully prepared for childbirth she learns how to work with her body to alleviate much of the discomfort of labor and delivery (psychoprophylaxis). There are many types of prepared childbirth classes that teach psychoprophylactic techniques (Lamaze, Bradley, Read, etc.); but their goal is the same: to have a happy, healthy, and safe delivery experience. If a woman feels she has some control over her body and behavior, she is more likely to need less medication and to be able to cooperate throughout the labor and delivery process. Childbirth education classes teach various relaxation and breathing techniques that help a woman to work with labor contractions and gain a sense of control over the childbirth process. In the Exercise Booklet you will find the exercises and breathing techniques we believe to be appropriate for the pregnant adolescent.

In the event that exercise practice sessions are not a part of the program you teach, we urge you to become familiar with whatever classes are available in your community. Teaching the exercises only once without regular practice sessions is not very effective for most young women. They need consistent reinforcement that comes from practice on a regular basis.

Another important aspect of prepared childbirth is the selection of a "coach." The "coach" is the person who goes through the labor and delivery process with the young woman, helping her with breathing and relaxation techniques. This person needs to be someone the woman trusts and someone with whom she feels comfortable. If a young woman doesn't have a person to act as coach, another student who has gone through childbirth education classes or even you may be selected for this position. The coach needs to practice with the expectant mother on a regular basis so that the mother learns to respond to the coach's cues.

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There are different philosophies regarding the use of analgesia and anesthesia during childbirth. A number of years ago "twilight sleep" was in vogue. Women were heavily medicated during labor because doctors didn't want their laboring women to experience any pain. Oftentimes their infants were born with severe respiratory depression. Hours after the delivery women were still groggy from the medication, and few were able to recall with any clarity the details of the childbirth experience.

With more and more research available on the effects of analgesia and tranquilizers on mothers during labor, the trend has shifted to the use of fewer and fewer medications. Any drug the mother receives during labor passes through the placenta and has some effect on the fetus. The larger the dose and the closer to the time of delivery the drug is given, the greater the effect may be on the child. Narcotics given to the laboring woman may result in respiratory depression in the newborn. Consequently, the less medication that is needed, the safer it seems to be for the baby.

The mother who desires early contact with her infant may have negative feelings about the use of analgesia or tranquilizers during her labor. These drugs tend to make the mother sleepier and less alert than the mother who has received no medication. Her desires should be respected unless there is a medical indication for the use of such drugs.

The philosophy and use of anesthesia during delivery continue to change. In the student text we have described different types of anesthesia, focusing on the nature and use of each. We deliberately did not stress the risks or side effects, as too much information can be confusing or frightening. The following information provided by Dr. Richard Murray, Director of the University of New Mexico Maternity and Infant Care Project, may be useful in helping you to explore with your students the use of anesthesia during labor and delivery.

Inhalation, general, or gas anesthesia was the most common form of anesthesia in the past and is used in some areas today. Inhalation anesthesia may be extremely simple, such as open drop ether, or extremely complex, requiring specialty training and expensive equipment. Although inhalation anesthesia, utilizing the expertise of a specialist, may be the anesthesia of choice in certain situations, such as in the cases of some Cesarean sections, potential problems make inhalation anesthesia undesirable for use in most obstetrical deliveries. Often women begin labor with food and liquid in their stomachs. Inhalation anesthesia frequently causes patients to vomit; and the risk of aspiration of stomach contents into lungs with potential serious complications is always present. There is also a possibility of respiratory depression in the infant immediately after birth.

Regional anesthesia has been used extensively in some areas and is becoming the most utilized form of anesthesia today. Two of the most common types of regional anesthesia are the saddle block and the epidural. Both of these types of anesthesia numb the nerves as they leave the spinal column in the lower back and alleviate the pain of contractions. A saddle block can be used only during the second stage of labor for the actual delivery because of its rapid onset of effect. Because the epidural takes longer to build up its effect and because it can be better controlled over a longer period of time, it is used to relieve pain during the latter part of the first stage of labor. The advantage of regional anesthesia is that the patient is awake and able to participate in the birth process. An added advantage is that there is little or no effect of anesthesia on the infant.

There are some risks, however, which occur infrequently. All regional anesthesia may result in a transient or temporary drop in the mother's blood pressure. Rarely there may be numbing of nerves at a higher level than desired which may require temporary management such as assisted respiration. Postanesthesia headaches do occasionally occur following saddle block anesthesia. There is also decreased ability of the patient to "push" to assist in the spontaneous delivery of the baby, frequently resulting in the use of forceps. Some women experience a temporary inability to urinate following delivery due to anesthetizing effects on the bladder.

Several forms of local anesthesia are used in labor and delivery. Young women can more easily understand the concept of local anesthesia if it is compared to the use of an injection by the dentist to numb a part of the mouth for filling a cavity in a tooth. Two types of local block anesthesia are the paracervical and the pudendal. A paracervical block may be utilized during the latter part of labor to numb the nerves in the cervix that transmit pain of cervical dilation and pain of uterine contractions. Depending on the dosage of the drug injected and the exact location of the injection, there may be a transient slowing of the fetal heart rate following paracervical block. The results of the paracervical block are not always reliable, and pain relief may be only partial and

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last only a relatively short period of time. The pudendal block is the numbing of a nerve that passes through the bones of the pelvis and supplies nerves to the perineum and vaginal outlet. The pudendal block is commonly used just prior to delivery for the relief of pain from the stretching in this area and for the episiotomy and its repair. Because this nerve block is usually given when the baby's head is very low in the pelvis, the patient frequently experiences some discomfort during administration.

A third type of local anesthesia, commonly called a "local," numbs only the soft tissues of the perineum where the episiotomy is made and repaired. The "local" does not block the stretching sensations from the opening of the vagina.

Once again, find out what the current analgesia and anesthesia practices are in your locality. Expounding to your students the virtues of epidural anesthesia only to discover that it is not used in your hospitals can lead to disappointment. If you focus only on the side effects of the various types, the young person who is to receive the anesthesia may be extremely fearful and resentful. Your goal is to inform her as clearly as possible what her choices may be and thus enable her to talk with her health care provider about her desires. Together they can make a decision about the use of analgesia and anesthesia for her childbirth experience.

I. Chapter Goals
  A. To discuss the importance of preparation as a favorable influence on the childbirth experience
  B. To provide information about the most commonly used types of analgesia and anesthesia for labor and delivery

II. Important Concepts
  A. Fear may unfavorably influence the progress of labor and delivery.
  B. Knowledge and use of relaxation and breathing techniques can favorably influence the progress of labor and delivery.
  C. The concept of "informed consent" is based on the patient's knowledge of and agreement to the nature of surgical and/or anesthetic procedures.

III. Learning Objectives

The student will be able to do the following:
  A. Explain what "natural childbirth" means;
  B. List two advantages of being prepared for childbirth;
  C. Explain the role of the labor "coach";
  D. Define *analgesia* and *anesthesia;*
  E. List each type of anesthesia for labor and delivery; describe the area of the body which is affected by each;
  F. Explain why gas (general) anesthesia is not commonly used for normal childbirth.

IV. Content Overview

Text Page

  A. "Natural childbirth" means prepared childbirth 60
    1. Purpose of preparation
    2. Exercises for breathing, relaxation, and body conditioning (refer to Exercise Booklet for complete details)
  B. Fear, tension, pain cycle 60
  C. Childbirth classes 60
    1. Types of exercises and breathing techniques
    2. Importance of practice

- D. Labor coach 60
  - 1. Role during labor
  - 2. Choice of this person
  - 3. Assistance provided by hospital personnel in absence of a coach
- E. Analgesia 61
  - 1. "Pain killers"
  - 2. Tranquilizers
- F. Anesthesia 61-63
  - 1. General (gas)
    - a. Limited use in normal deliveries because of danger of vomiting and aspiration in the mother
    - b. Limited use because of central nervous system depression in the newborn
  - 2. Regional
    - a. Saddle block or spinal
      - (1) Is administered immediately prior to delivery
      - (2) Numbs from waist to toes
      - (3) Blocks out the pushing reflex
      - (4) May necessitate the use of forceps
      - (5) May cause temporary inability to urinate
      - (6) May require patient to lie flat for six to eight hours after delivery
    - b. Epidural or caudal
      - (1) Is administered when the cervix is opened 5-6 cm.
      - (2) Numbs from waist to mid-thigh
      - (3) Blocks pushing reflex
      - (4) May necessitate the use of forceps
      - (5) May cause temporary inability to urinate
      - (6) May not be available in some hospitals
    - c. Nerve blocks
      - (1) Paracervical
        - (a) Is injected directly into cervix when patient is at least 4 cm. dilated
        - (b) Reduces pain from the dilation of the cervix
        - (c) May be repeated periodically
      - (2) Pudendal
        - (a) Is injected into the vaginal wall to numb perineum for episiotomy
        - (b) Is often used with "natural childbirth"
  - 3. Local

V. Suggested Learning Activities

- A. View films on prepared childbirth and the role of the coach.
- B. Share personal experiences of labor and delivery, emphasizing the importance of preparation.
- C. Invite a midwife to talk to the class about her training and her role in labor and delivery.
- D. Invite a doctor (or midwife) to talk about anesthesia.
- E. Invite a childbirth educator to talk about "natural childbirth" and selecting a "coach."
- F. Discuss or answer in writing the questions in part VI.

VI. Questions for Discussion/Study Guide

- A. In your own words, explain what "natural childbirth" means.
- B. Name three reasons why it is important to be prepared for childbirth.
- C. What is a labor "coach?" What can the "coach" do to help the mother during labor and delivery?
- D. What is analgesia? Why is it used during labor?
- E. What is anesthesia? Why is it used during labor and delivery?
- F. Describe the area of the body that is numbed by each of these types of anesthesia. Tell when each can be given.
  - 1. Saddle block or spinal
  - 2. Caudal or epidural
  - 3. Paracervical
  - 4. Pudendal
  - 5. Local
- G. Why is gas anesthesia *not* usually used for normal childbirth?
- H. Which type of anesthesia would you rather have? Why?

VII. Resource Materials

- A. Film: *Birth of a Family*
- B. Slide/Cassette: "The Childbirth Experience"
- C. Pamphlet: *Natural Childbirth,* Budlong Press
- D. Book: *Fathering, Participation in Labor and Birth,* Phillips and Anzalone

(For further references, please see book list in Chapter Nine.)

Chapter Eleven
"LABOR AND DELIVERY"
Pages 64-69

About the Chapter

The physiological and emotional aspects of labor and delivery are presented in this chapter. We have explained the process in simple terms with emphasis on what the mother will experience and on what she can do to facilitate childbirth.

In your discussion about labor and delivery, you may find that there are several words and/or concepts that are difficult for students to grasp. The word *LABOR* itself is best understood when it is used to mean "work" instead of pain. Many women think of labor as pain and of contractions as "labor pains." Contractions can be described as the tightening of the muscles of the uterus, which cause the cervix to open. There is discomfort and/or pain involved as the cervix stretches. Try to minimize your use of the word pain as it tends to condition young women to expect pain.

Young women seem to understand the physiology of labor better when the technical terms are related to everyday concepts that they can visualize. For example, the mucus plug that blocks the cervix during pregnancy can be likened to a plug in the sink or bathtub. To empty the contents of the sink or tub, the plug is removed. Likewise, the mucus plug, which has protected the contents of the uterus during pregnancy, must come out before the baby can come out.

Young women can be helped to understand the concept of dilation and effacement (the opening up and thinning out process of the cervix) when it is compared to the process of putting on a turtleneck sweater. As the neck of the sweater reaches the top of the head, the head exerts pressure on the neck and causes it to flatten against the head before it opens to allow the head to pass through. Another visual aid that can be used to demonstrate this process is the use of various size jars with different size openings. Longer-necked jars with smaller openings represent the cervix in the earlier stages of labor. Jars that have wide mouths and no necks represent the cervix as it nears the transition stage. These simple, everyday concepts can help young women grasp the more technical concepts of labor and delivery.

There seems to be a need in pregnant women to know exactly what labor will be like. The new mother who returns to your program may find herself bombarded with questions about her childbirth experience. Some new mothers tend to minimize the difficulty of the experience while others tend to be overly dramatic about "how awful it was." It can be helpful to both the new mother and to students who are still pregnant to have childbirth stories told in a controlled situation where the facilitator can guide the

discussion. You can help the young mother to be more realistic in her presentation if she seems to be either too positive or too negative. If she can discuss the value of being prepared, she may help students who tend to minimize the value of preparation to become more motivated in practicing relaxation and breathing techniques. Before asking a young mother to share her experiences, find out if she had any complications, as these might frighten pregnant students rather than allay the fears they already have.

You may want to discuss Cesarean births because the rate of Cesarean sections is higher among the teen population. A simple explanation of the procedure without a long dissertation on all of the complications that lead to C-sections tends to be the best approach. Too much information can cause confusion and intensify fear.

I. Chapter Goals

A. To reduce fear in the young mother by providing information about the physical and emotional processes of labor and delivery.
B. To help the expectant mother prepare for and confidently anticipate normal labor and delivery
C. To describe briefly birth by Cesarean section

II. Important Concepts

A. The ability to cope with the stress of labor and delivery is favorably influenced by knowledge and understanding of the normal physiology of labor and delivery.
B. Labor and delivery progresses according to a standard sequence of physiological events, subject to individual variations of time.
C. The individual's physical and emotional condition influences the progress of labor and delivery.
D. The incidence of Cesarean sections is higher among the teenage population.

III. Learning Objectives

The student will be able to do the following:
A. List the first three stages of labor and describe what happens in the body during each stage;
B. List three of the beginning signs of labor;
C. Explain three differences between true and false labor;
D. List at least three symptoms that may accompany the transition phase;
E. Describe the role of the laboring woman during the first and second stages of labor;
F. Define: *contraction, effacement, dilation, crowning, "fourth stage of labor," Cesarean section.*

IV. Content Overview

Text Page
A. Labor defined 64
B. Signs of labor 64
  1. Bloody show
  2. Rupture of bag of water
  3. Regular contractions
  4. Possible signs: sudden energy spurt, gas pains, diarrhea, and backache.
C. Contractions 64
  1. Tightening of the uterine muscles
  2. Timing of the length and interval
D. Distinguishing true from false labor ... 65
E. Stages of labor 65-69
  1. First stage
    a. This stage lasts from first true contraction to complete cervical dilation (10 centimeters or 4 inches).
    b. It involves effacement (thinning) and dilation (opening) of the cervix.
    c. The mother's feelings range from initial excitement during early labor to concentration on contractions.
    d. The transition phase may be accompanied by feelings of threat, fear, loss of control, and/or irritability.
    e. The mother's role is to rest between contractions and to relax during contractions.
  2. Second stage
    a. The stage lasts from complete dilation to delivery of the baby.
    b. Abdominal muscles are utilized to push the baby down and out.
    c. The degree of maternal participation and alertness are influenced by both type and amount of analgesia and/or anesthesia.
  3. Third stage
    a. The stage lasts from the delivery of the baby to the expulsion of the placenta (afterbirth).
    b. Maternal behavior may vary from interest in the infant to sleep from exhaustion.
  4. Fourth stage
    a. The first hour after delivery is the fourth stage.

b. The uterus contracts and rises to the level of the navel.
c. The mother may be sleepy, hungry, or excited.
d. The abrupt change in internal body pressure may cause trembling or tears.
e. Massage of the uterus to prevent hemorrhage may be very uncomfortable.
f. Mother-infant contact is beneficial for the development of the parent-child bond.

F. Cesarean section. 69
1. A C-section is the delivery of the baby through a surgical incision in the abdomen and uterus.
2. Anesthesia may be gas or spinal.
3. Reasons for this procedure include the following:
   a. Pelvic structure too small to accommodate passage of baby's head,
   b. Premature cessation of labor,
   c. Placenta previa — placenta positioned over cervical opening,
   d. Placenta abruptio — premature separation of placenta from uterine wall.

V. Suggested Learning Activities
A. View films on labor and delivery and Cesarean section.
B. Interview mothers who gave birth within the past year, five years ago, and ten years ago. If possible, interview a mother who delivered by Cesarean. Compare their experiences.
C. Share in pairs (or write a report on) the following:
   1. "How did you first learn about the birth of babies?"
   2. "Who told you?"
   3. "What did they tell you?"
   4. "How do you feel about the information?"
D. Role-play how to tell a three-year-old, seven-year-old, and twelve-year-old child about how babies are born.
E. Learn how to time contractions. Have a clock with a second hand available. Throughout the class period, announce that contractions are beginning and ending. Have the students record the time each contraction began and the duration of each contraction. At the end of the class, look at the times and have students tell whether these mock contractions are regular (sign of true labor) or irregular (false labor).
F. Discuss or answer in writing the questions in part VI.

VI. Questions for Discussion/Study Guide
A. List three signs that labor is beginning.
B. List three differences between true and false labor.
C. List the first three stages of labor. Explain what happens during each stage *and* what the woman can do to help herself during each one.
D. What happens during the "fourth stage of labor"?
E. Tell what the mother may feel during the transition phase of labor. (List at least three things.)
F. Define:
   1. Contraction
   2. Crowning
   3. Dilation
   4. Effacement
G. Is there anything about labor that scares you? If so, what?
H. What is a Cesarean section?

VII. Resource Materials
A. Films:
   1. *Birth Day, Through the Eyes of the Mother*
   2. *The Cesarean Birth Experience*
   3. *Have a Healthy Baby: Labor and Delivery*
B. Charts:
   1. "Birth Atlas" flipchart, Maternity Center Association
   2. "Cervical Dilatation," Ross Laboratories
C. Books: (Refer also to list provided in Chapter Nine)
   1. *A Baby Is Born*, Maternity Center Association
   2. *The Cesarean Birth Experience*, Donovan
   3. *Cesarean Childbirth, a Handbook for Parents*, Nickernell
   4. *Cesarean Childbirth, a Handbook for Parents*, Wilson and Hovey
   5. *Having a Cesarean Baby*, Hausknecht and Rattnet
   6. *Teenage Handbook for Prepared Childbirth*, Bradley

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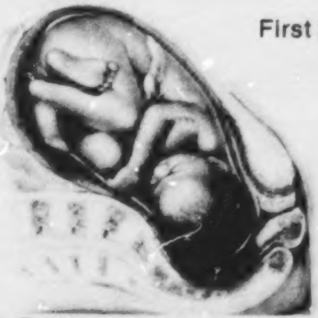
Mechanism of Normal Labor

To increase your knowledge of the labor and delivery process, we have developed the following chart which describes the mechanics of normal labor. The diagrams show the movement of the baby through the mother's pelvis during the labor and delivery process. The baby goes through a series of twisting and curving motions as his head adjusts itself to the size and shape of the mother's pelvis.

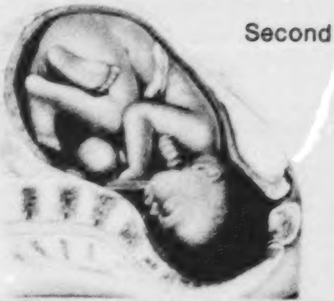
First Stage



1. Engagement
2. Descent
3. Flexion

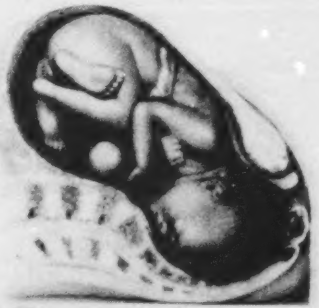
1. Engagement usually occurs before labor begins when the baby's head drops into the pelvis.
2. The head descends lower into the pelvis during the first stage of labor.
3. The chin touches the baby's chest as his head flexes during descent.

Second Stage



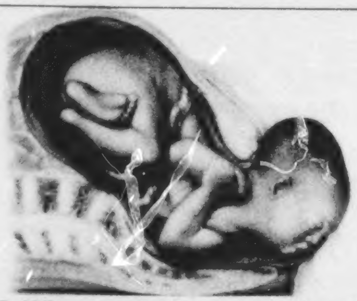
4. Internal Rotation

4. The head rotates to bring its longest diameter toward the longest diameter of the pelvic outlet.



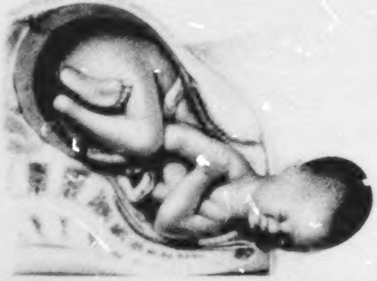
5. Extension Beginning

5. The pressure from contractions causes the head to extend from its flexed position upward toward the vaginal opening.



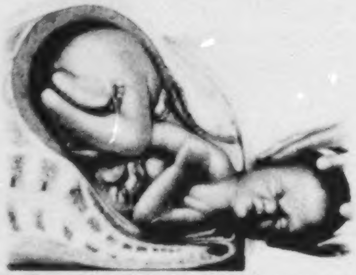
6. Extension Complete (Crowning)

6. When extension is completed, the crown of the baby's head can be seen at the vaginal opening.



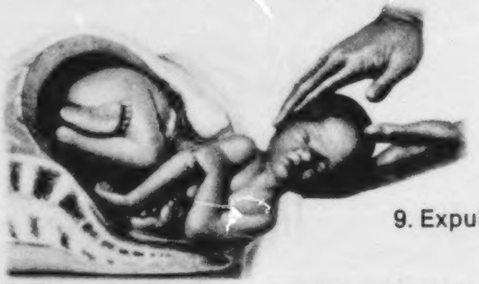
7. External Rotation (Restitution)

7. The head slips out of the vagina and turns to the side.



8. External Rotation (Shoulder Rotation)

8. The shoulders, which are now turned to the side, can be delivered one at a time: one from under the symphysis pubis (pubic bone) and one up and over the perineum.



9. Expulsion

9. The rest of the baby's body is quickly delivered, thus ending the second stage of labor.

Pictures from *Mechanism of Normal Labor* (Clinical Education Aid No. 13), Ross Laboratories, Columbus, Ohio.

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Chapter Twelve
"AFTER THE BABY'S BORN ... NOW WHAT?"
Pages 70-73

About the Chapter

In this chapter we have discussed the physical and emotional changes of the postpartum period and good health care practices that will foster a normal recovery. To help a young woman over the transitional period from the pregnant to the non-pregnant state (usually associated with becoming a mother), it will probably be helpful for you to understand in more depth the implications of the fourth trimester.

The fourth trimester is an expansion of the postpartum period concept. This period encompasses not only the first six weeks following delivery but the next six weeks as well. The most rapid and dramatic changes take place in the woman's body and in her life during the first six weeks. It often takes three months or longer for a complete transition to occur, particularly in the young mother who is coping with adolescent developmental tasks as well.

Reva Rubin, a noted nursing educator and author, has written many articles on the changes experienced by a woman during the fourth trimester. From the moment of delivery, there are dramatic changes taking place in the woman's body. The initial weight loss of ten to fifteen pounds, the decrease in body fluids, and the return of the intestines to their pre-pregnant position would be enough to cause shock and excruciating pain in anyone but the new paturient (newly delivered woman). In addition to these physical changes, a new role with its new tasks is also beginning.

Rubin describes the first two or three days following delivery as the "taking-in" phase. There is a need for sleep and food as the body adjusts to its new state. The woman is usually passive and dependent and is willing to let others care for her as she "takes-in" in preparation for her new role. Many women are quite verbal during this time, exhibiting a need to review the labor and delivery experience. Talking about labor and delivery helps them to put it in proper perspective and, eventually, to put a closure on the experience. If you visit the young woman in the hospital, you may be the person who can listen to the details of her labor and delivery.

The second phase is the "taking hold" stage which lasts ten days to two weeks. During this time the young mother begins to assert some independence. It becomes extremely important for her to gain control over her bodily functions. If she can have a bowel movement and take a shower on her own, she experiences confidence in her ability to be more independent. When she has achieved some degree of autonomy, she can begin to take hold of some of the tasks of mothering. During this phase she is usually an eager learner, wanting to know all she can about infant care. We have noticed in our own students that frequently the information about infant care that they "learned" during pregnancy may be suddenly gone. Often the immediate concern of preparing for labor and delivery overshadowed their ability to really "learn" much about infant care. During the postpartum period, the prospects of mothering become a reality; and suddenly there is a great need to learn all one can about taking care of a baby.

The third phase is described by Rubin as the "letting go" stage. This period takes time as the mother lets go of her past with its old roles and fantasies and accepts the reality of her child and her new role as a mother. She may have feelings of depression and jealousy as she adjusts to the fact that her baby is no longer inside her body and to the fact that she is no longer the center of attention. Especially difficult for the young mother are the ambiguous feelings of changing from a child to the new role of mother.

Body Image

Body image is a concern of most new mothers. Many women find they were better prepared to accept the changes in their bodies during pregnancy than they are the changes that occur following delivery. Younger women, especially, think that somehow the body will return immediately to the pre-pregnant state as soon as they deliver. They are not prepared for the discomfort from their episiotomies or for the bodily discharges such as perspiration, lochia (the bloody discharge from the vagina), or leakage from their breasts. Problems with urinating or having a bowel movement may further complicate a new mother's feelings about her body. Often the biggest disappointment experienced is a flabby, protruding abdomen. The new mother feels so thin and light, yet she can't button her waistband! Careful preparation for what to expect following delivery can help to alleviate the depression some women experience from a poorly functioning body. Reassurance that these discomforts are only temporary helps young women to feel better about their body images.

"Fantasy Mother" vs. "Reality Mother"

Another area that a young woman needs help with is thinking about herself in the mothering role. There may be a big difference between what she thinks a mother is supposed to be like and the real mother role. Margot Edwards, another noted nursing author, indicates that often a woman fantasizes the mothering role as "super-mom." A "super-mom" is very demanding of herself and won't allow time for rest or personal activities. When the new mother should be resting, she may experience guilt that the house isn't as clean as it should be. She can never live up to her own expectations and, therefore, may have periods of depression. The "nurturing mom," on the other hand, will allow herself adequate rest periods because she feels she deserves it. She doesn't worry about a messy house and will take time for herself. In other words, she sees that there can be pleasure in her life. If a young woman can be helped to understand the importance of rest, good nutrition, and giving herself some "strokes," then the "reality mother" is more apt to be lenient and to find more enjoyment in the new role.

Postpartum Depression

Postpartum depression is a medical condition requiring professional help that sometimes occurs in new mothers. It is not to be confused with the "baby blues" which is a mild form of depression that frequently follows childbirth. Both conditions are caused by hormonal changes after the birth of a baby; postpartum depression, however, occurs when a woman is unable to cope with her new role and the responsibilities of being a mother. The new mother experiences depressed feelings that last for hours, or even days; and that occur predictably on a daily basis. She doesn't "feel like herself." The condition lessens as the woman develops confidence in her mothering ability, and time is frequently the greatest healer. Because professional counseling is often needed, be alert to the possibility of this need and make appropriate referrals.

Support System

The adjustments made during the fourth trimester are easier when there is a good support system available. For many young women, support is available from their immediate families. If a young woman lives at home, her own mother may be a big help. Difficulties can arise, however, if the girl and her mother haven't discussed the roles each will assume. Ideally the girl's mother should be available to help with housework and cooking, leaving most of the care of the baby to the young mother. In this way the young mother can develop some confidence in her own mothering ability without feeling threatened by her mother's apparent expertise. Needless to say, the grandmother can be of great help in answering questions or acting as a sounding board or even baby-sitting. The majority of child care, however, should ideally be done by the young mother for a good mother-infant attachment to take place.

Other types of support may come from the baby's father. We often lose sight of the fact that he may be the young mother's main support. She may need help in understanding that he has needs, too! He also is adjusting to a new role and may feel threatened by the new baby. The young couple may need help in establishing their new family.

Outside support from professionals can be helpful during the fourth trimester. Phone calls and/or home visits during the first week or two after the young mother goes home from the hospital have proven helpful. Reassurance, information, and positive reinforcement can help the young woman in her adjustment to her child. It is important to focus your attention on *her* at this time, rather than concentrating your energies entirely on the well-being of the baby.

When visiting the young mother, be alert for opportunities to note what she is doing well. Assist her in finding qualities and characteristics she likes about her baby. It is also helpful to find out what her expectations are for herself and for her child. If her expectations seem unrealistic, which they often are, help her to formulate expectations that are more consistent with her situation and with the abilities of the newborn.

The fourth trimester is a period of change and adjustment to new roles. Be sensitive and supportive to the needs of the young women with whom you work. It can be very rewarding to watch the growing independence and healthy mother-child relationships that develop!

I. Chapter Goals
  A. To discuss normal physical and emotional changes and care during the postpartum period
  B. To provide anticipatory guidance to help the new mother cope with the early period at home

II. Important Concepts
  A. The process of postpartum involution follows a standard sequence of physiological events, subject to individual variations of time, initial physical condition, and quality of care provided.
  B. Recovery of normal body condition during the postpartum period is influenced by rest, nutritional status, exercise, and personal hygiene practices.
  C. Normal hormonal changes during the postpartum period, and change in role/life style may cause emotional instability in the new parent.

III. Learning Objectives
The student will be able to do the following:
  A. Name three changes which take place in the woman's body during the six weeks following childbirth;
  B. Name three things a new mother can do to facilitate recovery;
  C. Explain why the newly delivered mother has a bloody vaginal discharge (lochia) for three to six weeks after childbirth;
  D. Explain why some women experience depression following the baby's birth and describe three ways a woman can help herself during this time;
  E. Explain what happens at the postpartum check-up;
  F. Describe five aspects of care for the woman recovering from a Cesarean birth;
  G. Define: *engorgement, "afterpains," involution.*

IV. Content Overview

Text Page

  A. Physical changes and care during postpartum........................ 70-73
    1. Weight loss due to increased perspiration and urination
    2. Regaining of muscle tone in abdomen and vagina
    3. Appetite decrease
    4. Involution of uterus
      a. The uterus gradually returns to normal size and position.
      b. The uterus is no longer felt in the abdomen after ten days.
      c. "Afterpains" are more common in women who have had several children and in women who breastfeed.
    5. Lochia
      a. Lochia is a secretion from the open wound at the site of the placental attachment.
      b. The bloody vaginal discharge gradually changes from bright red to yellow.
      c. Lochia usually disappears in three to six weeks.
      d. Cleanliness of the perineum is important.
    6. Breasts
      a. Non-breastfeeding mothers need special care.
        (1) Non-breastfeeding mothers receive medication to help prevent lactation.
        (2) Non-breastfeeding mothers can expect breasts to return to normal size in four to six weeks.
      b. Breastfeeding mothers have common characteristics.
        (1) Colostrum is produced until milk production begins.
        (2) Lactation occurs in two to four days after delivery.
        (3) Engorgement is a sign that milk production has begun.
        (4) Breasts remain enlarged throughout the lactation period.
      c. Supportive bras are encouraged for both nursing and non-nursing mothers.

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7. Healing of episiotomy
   a. Stitches dissolve in one or two weeks.
   b. Soaking in warm water eases discomfort and promotes healing.
   c. Regular bowel movements facilitate healing and comfort.
8. Menstruation
   a. Non-nursing mothers usually have a period within 12 weeks.
   b. Nursing mothers may not have a period until lactation ceases.
   c. Ovulation can occur at any time after delivery.
   d. Pregnancy is a possibility even though the mother may not have had a period.
9. Postpartum check-up at four to six weeks
10. Care following Cesarean birth

B. Resumption of normal activity 71, 72
   1. Sexual intercourse should be delayed until all bleeding has stopped and episiotomy is healed.
   2. Bathing may be resumed at any time.
   3. Naps and extra rest will be required until strength has been regained.
   4. Regular school and work activities may be resumed within two weeks if everything is normal.

C. Emotional adjustment 73
   1. "Baby blues" are common.
      a. Blues are caused by hormonal and psychological changes.
      b. Blues are helped by diversion.
   2. Maternal feelings vary.
      a. Maternal feelings develop gradually.
      b. Maternal feelings may not be as expected.

V. Suggested Learning Activities

A. Respond to the following letter:
"I had my baby ten days ago. Most of the time I am very happy and feel real good. Sometimes I seem to cry for no reason at all. Is this normal? What can i do?"

B. View films on postpartum experience and Cesarean birth.

C. Utilize the 3" x 5" question card technique (see Chapter 5, Suggested Learning Activities). Questions should deal with changes and care during the postpartum period.

D. Invite a panel of young women (one who kept her baby and is single, one who is married, and one who released) to discuss their adjustments following childbirth.

E. Discuss or answer in writing the questions in part VI.

VI. Questions for Discussion/Study Guide

A. The first six weeks after delivery are called the postpartum period. Name at least four changes that will happen to the mother's body during this time.

B. Name at least five things a new mother can do to help her body return to normal after childbirth.

C. After delivery a woman has a bloody discharge called lochia for about four to six weeks. Explain why.

D. Many women get the "baby blues" soon after delivery. Why does this happen?

E. Name three things a new mother can do to help herself with the "blues."

F. How is a woman's care different if she has had a Cesarean birth?

G. What is the purpose of the postpartum check-up?

H. Define:
   1. Engorgement
   2. "Afterpains"
   3. Involution

VII. Resource Materials

A. Films:
   1. *Are You Ready for the Postpartum Experience?*
   2. *The Cesarean Birth Experience*

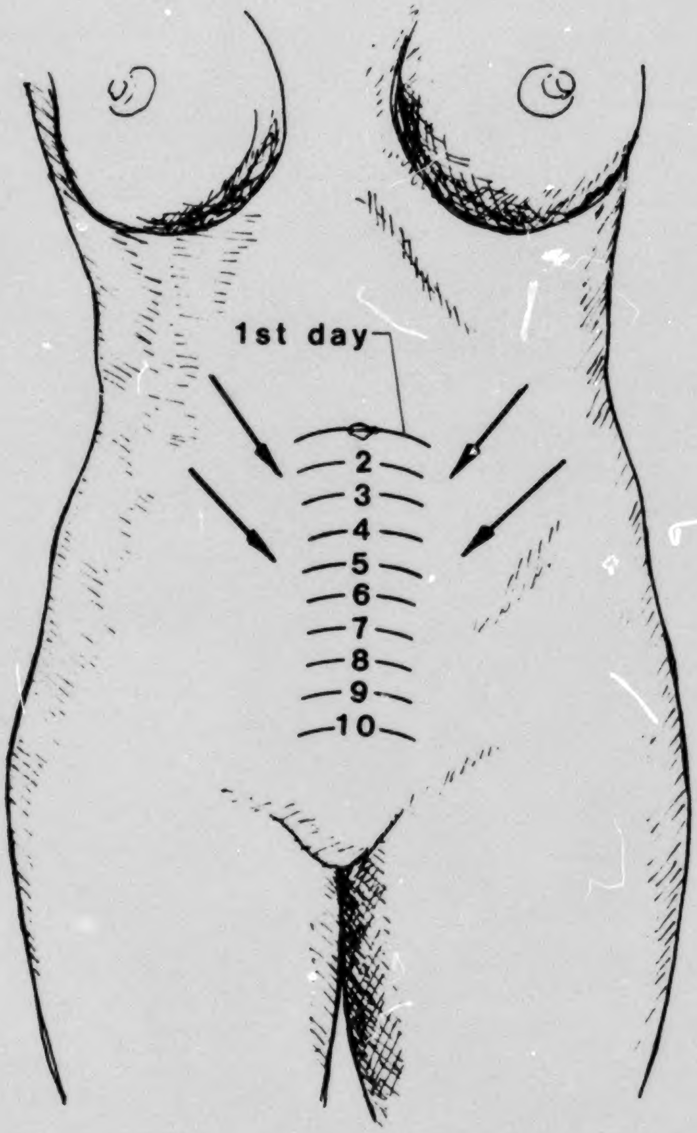
B. Pamphlets:
   1. *Caring for Yourself After Your Baby Is Born*, Ross
   2. *Your New Baby and Your New Life*, Budlong Press

C. Books:
   1. *The Cesarean Birth Experience*, Donovan
   2. *Now That You've Had Your Baby*, Panter and Linde
   3. *The Post Partum Book: How to Cope With and Enjoy the First Year of Parenting*, Pizer and Garfink

D. Articles:
   1. "The Crisis of the Fourth Trimester," Edwards
   2. "Family Crisis in the Fourth Trimester," Taggert
   3. "Maternity Nursing Stops Too Soon," Rubin
   4. "Puerperal Change," Rubin

INVOLUTION

The Return of the Uterus to Its Normal Size and Position



The first day following delivery of the baby, the uterus is at the level of the umbilicus (belly button). Each day it moves further back down into the pelvis.

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Chapter Thirteen
"HELLO, STRANGER!"
Pages 74-80

About the Chapter

The purpose of this chapter is to acquaint the young parent with the newborn infant. The emphasis is upon the emotional and physical needs of the young one. For several reasons we have intentionally avoided discussing the techniques of baby care in detail. First, we feel there are many well-done pamphlets, books, and kits on the subject available at little or no cost. We see no reason to duplicate these materials. Second, in working with a multi-ethnic population, we find a wide diversity in the specific techniques and practices of baby care. Finally, we believe that it is of *primary* importance that the young mother develop realistic expectations for the behavior of a newborn and that she become aware of his emotional, physical, and psychological needs.

The newborn is not always what the parent had anticipated. Prior to the baby's birth, the mother tends to fantasize her baby as looking and acting "ideal," almost as if the child were a doll. She needs assistance in adjusting to the realities of her infant. The earlier the mother can identify with her infant and can "claim" the baby as her own, the stronger will be the mother-child bond. Pointing out the desirable characteristics of the baby and the child's resemblances to the mother and other family members is often helpful. Be careful, however, because pointing out resemblances to persons the mother dislikes can create barriers between mother and child!

In some cases the young woman may experience serious disappointment in sex, characteristics, or behavior of the newborn. It is important to help her discover qualities about the child that she does like. Be careful, however, not to discount her feelings of disappointment and grief. These feelings are quite real and may be very intense. If she has an opportunity to release these emotions by crying or talking about them, she will then be better able to accept the real child.

The responses of the baby to the mother are of vital importance in the establishment of their early relationship. The mother looks for reinforcement from the child, for some indication that he loves and needs her. The young mother may need assistance in noting the baby's responses to her. She may misinterpret some behaviors and may need help in perceiving responses in a new way. For example, some infants are difficult to arouse. To an insecure young parent, slow arousal may be seen as a sign of disinterest or rejection. You can help by reminding her that some people need more sleep than others. In this way she can come to understand and accept her baby's characteristics better.

There is a tendency among young parents to compare their children with others. Comparisons can be hazardous if they lack respect for the concept of individual differences. The young mother may need help in assessing the temperament and needs of her baby, in developing a sensitivity to the personality of her child, and in developing appropriate responses. A high-strung child will need gentle, quiet handling while a sleepy child may respond well to stimulating interactions.

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Crying

It is a *very* common belief among teen parents that picking up a crying baby will result in spoiling. They seem to feel certain that frequent handling trains infants to be demanding and unreasonable. *Research indicates that the opposite is true!* Infants who are responded to with consistency and promptness tend to develop trust in their relationships with others. In addition, they are more likely to communicate with their mothers in ways other than crying as they grow older.

This message will require frequent repetition! The most effective method we have found is to have the girl imagine what it's like to be a small helpless person who needs assistance with pain, hunger, or loneliness. Often it is then easier for the young parent to understand the frustration and lack of trust that results from thwarted needs.

In addition, it is helpful to spend time discussing the various types of cries. The young mother can learn to distinguish between the urgent cry of pain or hunger and the dull, nagging cries of tiredness or boredom. It is also useful to discuss methods of holding the baby upright and diverting his attention through movements, sounds, or visual stimuli. Encourage the mother to experiment with various responses until she finds the type of consolation that will work for her and her baby.

There will be times, of course, when *nothing* can console the crying child. Babies may cry from overexhaustion, overstimulation, or other seemingly inexplicable reasons. Reassure the young mother that if she has done all she can she may simply have to put the baby to bed and wait until he cries himself to sleep.

It is important to let teen parents know that there *will* be times when they feel frustration and anger at their children. They often feel quite guilty about these feelings and may be reluctant to admit them. Help them understand that occasional negative feelings are to be expected and that methods of coping can be developed. Such self-acceptance may be helpful in times of stress. If you are a parent yourself, you may want to share stories of experiences you have had with your children. We have found such "story-telling" to be not only reassuring but also an excellent teaching tool.

The first year of life is considered to be a very significant time in the development of the child. During these first months, the baby makes "decisions" about what kind of place the world is and develops an early concept of self-worth. The most important factor during that first year is that the baby develop an attachment to at least one other person. If this person is responsive to his needs in a consistent, loving manner, the child develops a sense of trust and well-being that is the basis for much of his other development. Young parents need to understand this concept and to learn practical methods for meeting the baby's physical and emotional needs.

Characteristics and Care of the Newborn

For a young mother to be able to accept her infant and to meet his emotional and physical needs, she needs a basic understanding of the newborn's physical characteristics. In the book we have listed the basic physical characteristics of the baby. We suggest that you elaborate on these as much as your time allows.

Head

Teen mothers are often shocked at the size of the baby's head. The length of the head is approximately one-fourth of the total body length. This is a result of the early brain development that takes place in the human. The shape of the head may have been affected by the birth process. There may be red marks on the face if forceps were used in delivery. It will be helpful to reassure the young mother that in a very short time the head will become more rounded and the red marks on the face will disappear. There may also be concern about fontanels (soft spots). Explain that these result from the bones of the skull not having fused yet. The skin that covers the fontanel is quite strong, and there is no danger in washing or touching the area.

Eyes

At birth the pigmentation of the eyes may be incomplete. Often this incomplete pigmentation gives them a slate-blue appearance. The color of the eyes may change as the pigmentation process is completed. The eyes may appear swollen, red, or runny. These conditions may be due either to the pressure from the birth process or to the medication that is placed in the eyes following birth. The tear ducts are not usually functioning in the newborn. To cleanse the eyes, the young mother should be encouraged to use clean, warm water on a cottonball, wiping from the inside corner outward. A separate piece of cotton should be used for each eye to avoid possible spread of infection.

One of the greatest concerns young parents have is that the baby's eyes appear crossed or seem to roam. Reassure them that these conditions are usually the result of lack of muscle coordination. As the baby develops these muscles, he will begin to focus more easily; and his eyes will no longer cross.

Nose and Ears

Many babies are born with flat noses. In some cases a flat nose may be related to the birth process. However, nature also has a hand in the shape of the infant's nose. The small, flat nose allows the baby to breathe more easily while he nurses. There may be a mucus discharge that can be removed by gentle suctioning with a bulb syringe. The bulb should be squeezed before it is inserted into the nostril. The pressure is then released, drawing the mucus into the syringe. Small, twisted pieces of moistened cotton can be used to clean the remaining mucus from the nose. Caution that inserting Q-tips into the nose can be dangerous.

The care of the ears is similar in that cotton balls or washcloths should be used instead of Q-tips. To avoid damage to the eardrum, only the outer shell of the ear should be cleaned.

Chin and Neck

The receding chin and the short neck are also characteristics that facilitate the sucking process. The chin and jaw actually develop as a result of sucking.

Body

Characteristically, the upper body of the newborn is more fully developed than the lower portion. Young parents are usually interested to learn that the child's development proceeds from head to foot. This *cephalo-caudal* development is due to the fact that the upper extremities are nearer to the brain. Babies gain coordination in the upper extremities first. An understanding of these simple principles serves as a basis for learning the developmental sequence. It will help parents understand why babies learn to crawl before they learn to walk, etc. Another area of interest is the oftentimes noisy, erratic breathing of the newborn that is due to the immaturity of the respiratory system.

Skin

Recommended skin care practices vary widely among health care providers and cultural groups. In general there is no medical reason for removing the vernix. The most important element of skin care is the stimulation and contact it provides for the infant as well as for the mother.

Young mothers may be concerned about dryness and flaking of the baby's skin. Reassure them that this condition is normal, the result of the prolonged immersion in water during pregnancy. Many health care providers recommend the use of mild lotions rather than oils or powders.

There is some evidence that powders can be dangerous if inhaled into the baby's lungs. Cornstarch is less expensive and is safe and effective in absorbing moisture. Some mothers may be enthusiastic about the combined use of lotions and powders. When used at the same time, lotions and powders may form a "paste" that tends to clog the pores of the skin. The skin in the diaper area should be cleansed with warm water each time the diaper is changed.

Cord

Cultural practices regarding cord care and disposal vary widely and often carry great significance. It is important to familiarize yourself with the customs of the people with whom you are working. We have recommended in the text that the cord be kept clean and dry. Alcohol can be applied to the base of the cord until it falls off. The use of belly binders is considered to be very important by some of our students. When binders are used, it is essential that they be clean and dry and that the cord area be kept clean.

Genitals

In both sexes the breasts and genitals of the newborn often appear enlarged or swollen. This swelling is caused by the hormones received from the mother while the infant is still in the uterus. The breasts may secrete a milky substance sometimes called "witches milk." The swollen breasts are tender and easily irritated. There may also be a slight bloody discharge from the vagina. These symptoms are not cause for concern and will soon disappear. When bathing a baby girl, the mother should be taught to spread the lips (labia) of the vagina and wash in a front-to-back direction.

Erections occur very early in baby boys. If the baby is not circumcised, the mother should be taught to retract the foreskin to clean around the head of the penis. Methods and care of circumcisions vary somewhat. The health care provider will instruct the young mother in appropriate care of the circumcision.

Abilities of the Newborn

Research continues to uncover new information regarding receptivity, awareness, and physical capabilities of the young infant. Because babies may often *appear* to be unaware of their surroundings, young parents may not be aware of the degree to which the baby can and does interact. It is exciting to discuss the capabilities of the infant with the new parent. Parents usually enjoy discovering their baby's responsiveness. They also enjoy learning that the baby's senses are more highly developed than once was understood. Researchers have now discovered that very young infants respond with body movements to the rhythm and pitch of someone's voice. Babies who have had early skin-to-skin contact with their parents learn to recognize their parents by smell. A breastfed baby can distinguish his own mother's milk by smell. Touch is one of the best means of communication with the tiny newborn. We urge you to keep current on the latest research being done with infants. The works of Marshall Klaus and Berry Brazelton are of particular value.

Developmental Patterns and Sequences

We have had several requests from teachers for charts that list developmental milestones. It has been our experience that the use of such charts may create very specific expectations for the infant's development at certain ages. Development does follow an orderly and sequential pattern. However, there is a wide variation in the exact age at which these abilities are developed. If a young mother has expectations that her child does not meet, she may be concerned and disappointed. In our opinion it is preferable to discuss general developmental sequences and patterns without specific reference to chronologic age.

Whenever possible, it is helpful to work with mothers individually to teach them ways to facilitate the growth and development of their own children. In this way the danger of comparisons with other children can be somewhat alleviated. Individual work with mothers also provides the opportunity to emphasize what the child *can* do and to suggest appropriate learning activities.

Young parents often fall prey to advertisements or to high pressure salesmen who imply that the child's development will somehow be hindered if the parent does not purchase a certain product. Since young people are inexperienced in dealing with such propaganda, they are likely to purchase an unnecessary and high-priced article. We recommend that you discuss inexpensive sources of layette and toys. In addition, parents usually enjoy making such items when they realize that "homemade" is as good for the child as "store bought."

I. Chapter Goals

- A. To explain the characteristics of the newborn infant
- B. To emphasize the emotional needs of the infant and their importance during the early years of life
- C. To discuss the physical needs of the young infant
- D. To help the mother understand that her baby is an individual whose needs may differ somewhat from those of other babies
- E. To provide simple, practical suggestions for meeting the physical and emotional needs of the young infant

II. Important Concepts

- A. Newborn infants have some general characteristics in common, the exact nature of which may vary from one infant to another.
- B. Newborns have a need to develop a strong emotional attachment to at least one human being during the first year of life.
- C. The development of the infant's self-concept and sense of trust begins at birth and is dependent upon consistent, nurturing care.
- D. Each newborn is an individual with unique physical and personality characteristics that are determined by both genetic and environmental factors.
- E. The parent's acceptance of and adaptation to the child's personality favorably influence the parent-child relationship and enhance the child's self-esteem.

III. Learning Objectives

The student will be able to do the following:

- A. Describe six physical characteristics which are common to most newborns;
- B. List four things the infant is able to do at birth;
- C. Explain what is meant by "tender, loving care" and why it is important to the infant;
- D. List two important points to remember when meeting an infant's needs for each of the following: feeding, bathing, clothing, and health care;
- E. List four immunizations a baby should receive;
- F. List six important safety measures to follow when caring for an infant.

IV. Content Overview

Text Page

- A. "Fantasy" vs. "Real" baby 74
- B. Common characteristics 75
  - 1. Head
  - 2. Eyes
  - 3. Nose
  - 4. Soft spot
  - 5. Chin and neck
  - 6. Body
  - 7. Skin
  - 8. Hair
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- C. Abilities of the newborn 76
  - 1. Sucking
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  - 3. Seeing
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  - 5. Touching
  - 6. Crying
- D. Early infant behavior 77
  - 1. Temperament differences
  - 2. Sleeping and eating patterns
- E. Emotional needs of newborn 77
  - 1. Tender, loving care
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- F. Physical needs of newborn 78, 79
  - 1. Feeding
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- G. Health Care 80
  - 1. Importance
  - 2. Signs of illness
- H. Immunizations 80
  - 1. Diphtheria
  - 2. Whooping cough (pertussis)
  - 3. Tetanus
  - 4. Oral polio drops
  - 5. Measles
  - 6. Rubella (German measles)
  - 7. Mumps
- I. Safety 80

V. Suggested Learning Activities

- A. Make a list of things that a mother should know before her baby is born. Then have students do the following:
  - 1. Check those items that they have already learned.
  - 2. Find out where they can learn about the ones they don't know.
- B. List some things that can be put in a baby's room to help his eyes and ears develop.

C. Bring in toys from home and examine them for safety and appropriateness for developmental levels.
D. Make a safe, colorful toy for a baby.
E. Make a collage depicting the physical and emotional needs of infants.
F. Listen to a tape of babies' sounds and discuss their messages.
G. View films about newborns, immunizations, and safety.
H. Visit a nursery or day-care center to evaluate the care the children receive; observe feeding, playing, bathing, holding, sleeping arrangements, etc.
I. React verbally or in writing to the statement, "Newborn babies *can't* be spoiled!"
J. Relax and fantasize being helpless newborns, as described on p. 77 of the text. Discuss how it felt to need care and to have to wait to get it. Discuss the change in feelings when needs were met.
K. Give a baby bath or formula preparation demonstration.
L. Make clothing for a baby's layette.
M. Make a list of items that are essential for a layette. Go to several stores and compare prices of the various items.
N. Bring a newborn to class, and discuss characteristics and abilities.
O. Invite a public health nurse to discuss immunizations and well-baby care.
P. Discuss or answer in writing the questions in part VI.

VI. Questions for Discussion/Study Guide
A. Describe the following things about a newborn:
  1. Head
  2. Eyes
  3. Nose
  4. Soft spot
  5. Chin and neck
  6. Body
  7. Skin
  8. Hair
  9. Cord
B. List six things a baby can do as soon as he's born.
C. Why is tender, loving care important to an infant?
D. List five ways you can give a baby tender, loving care.
E. What happens to a baby who does not get his needs met?
F. Why is it important to hold a small baby when you feed him?
G. What advice would you give a new mother about clothing for her baby?
H. What are three important things to remember when giving a baby a bath?
I. The DPT shot protects your baby from which three diseases?
J. The MMR shot protects your baby from which diseases?
K. How is the polio immunization given to a baby?
L. List six important safety rules for babies, and tell why each is important.
M. There are many other safety rules that aren't in the book. Think of three.
N. Sucking is important to a baby to be able to get food. Give another reason why sucking is important.
O. How do you feel about letting a baby suck on a pacifier?
P. Give three reasons why babies cry.
Q. Why is it important to go to your baby when he cries?

VII. Resource Materials
A. Films:
  1. *Accident Prevention*
  2. *The Amazing Newborn*
  3. *Baths and Babies*
  4. *First Two Weeks of Life*
  5. *A Gift, an Obligation*
  6. *How Babies Learn*
  7. *The Newborn*
B. Filmstrip/Cassette: *Infant Care and Development Series*
C. Charts:
  1. "Baby Chart," Johnson and Johnson
  2. "Newborn Baby," Maternity Center Association
D. Pamphlets:
  1. *Baby Care Basics*, Johnson and Johnson
  2. *First Time Parents*, Johnson and Johnson
  3. *Getting to Know Your Newborn*, Johnson and Johnson
  4. *Infant Care*, DHEW #76-30015
  5. *The Phenomena of Early Development*, Ross
E. Books:
  1. *Baby and Other Teachers*, Aaronson and Rosenfeld
  2. *The Baby Exercise Book*, Levy
  3. *Baby Learning Through Baby Play*, Gordon

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4. *Baby to Parent, Parent to Baby*, Gordon
5. *Child Care*, Greenberg, et al.
6. *The Complete Guide to Preparing Baby Foods at Home*, Castle
7. *"Feed Me — I'm Yours!"* Lansky
8. *The First Three Years of Life*, White
9. *The First Twelve Months of Life*, Caplan
10. *From One to Two Years*, Segal and Adcock
11. *Infants and Mothers: Differences in Development*, Brazelton
12. *Infants: Development and Relationships*, Smart and Smart
13. *Learning Games for Infants and Toddlers*, Lally and Gordon
14. *Maternal-Infant Bonding*, Klaus
15. *9 Months, 1 Day, 1 Year*, Marzollo
16. *Neonatal Behavioral And Assessment Scale*, Brazelton
17. *The Rights of Infants*, Ribble
18. *The Second Twelve Months of Life*, Caplan
19. *The Taming of the C.A.N.D.Y. Monster*, Lansky
20. *Toddlers and Parents*, Brazelton
21. *Your Baby and Child, From Birth to Age Five*, Leach

F. Articles:
1. "Individual Differences at Birth: Implications for Child Care Practices," Korner
2. "Infant Crying and Maternal Responsiveness," Bell and Ainsworth

IMMUNIZATION RECORD

Baby's Name: ______________________

Date of Birth: ______________________

BE SURE TO KEEP A RECORD
OF ALL OF YOUR BABY'S SHOTS!

DPT (Diphtheria, Whooping Cough, Tetanus, given together)

	Date Given	Place
2 months	________	________
4 months	________	________
6 months	________	________
18 months (Booster)	________	________
5 years (Booster)	________	________
POLIO (given orally)		
2 months	________	________
4 months	________	________
6 months	________	________
1st Booster	________	________
2nd Booster	________	________
MMR (Measles, Mumps, Rubella, given together)		
13-15 months	________	________

It is important for young parents to keep records of their children's immunizations. You may find this sample immunization record convenient for reproduction.

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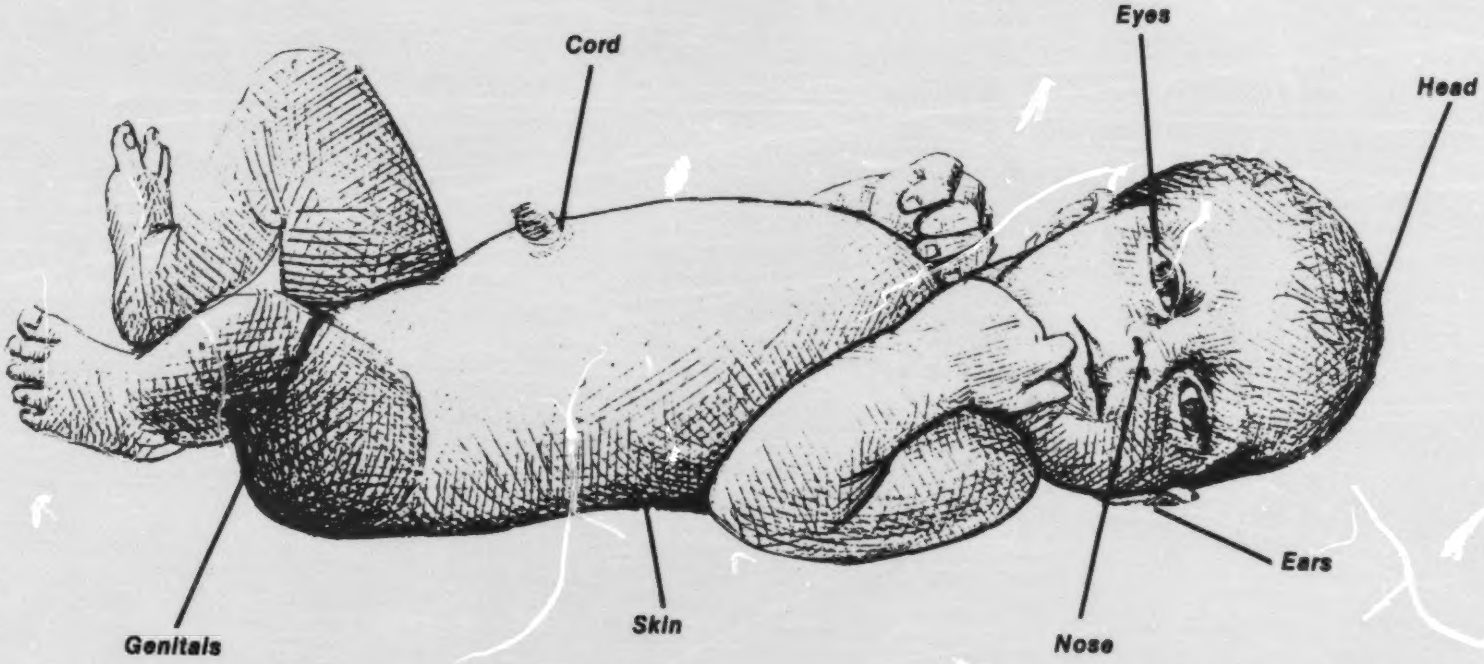
Describe the care that is given to each of the body parts listed below:


Eyes
Cord
Head
Ears
Genitals
Skin
Nose

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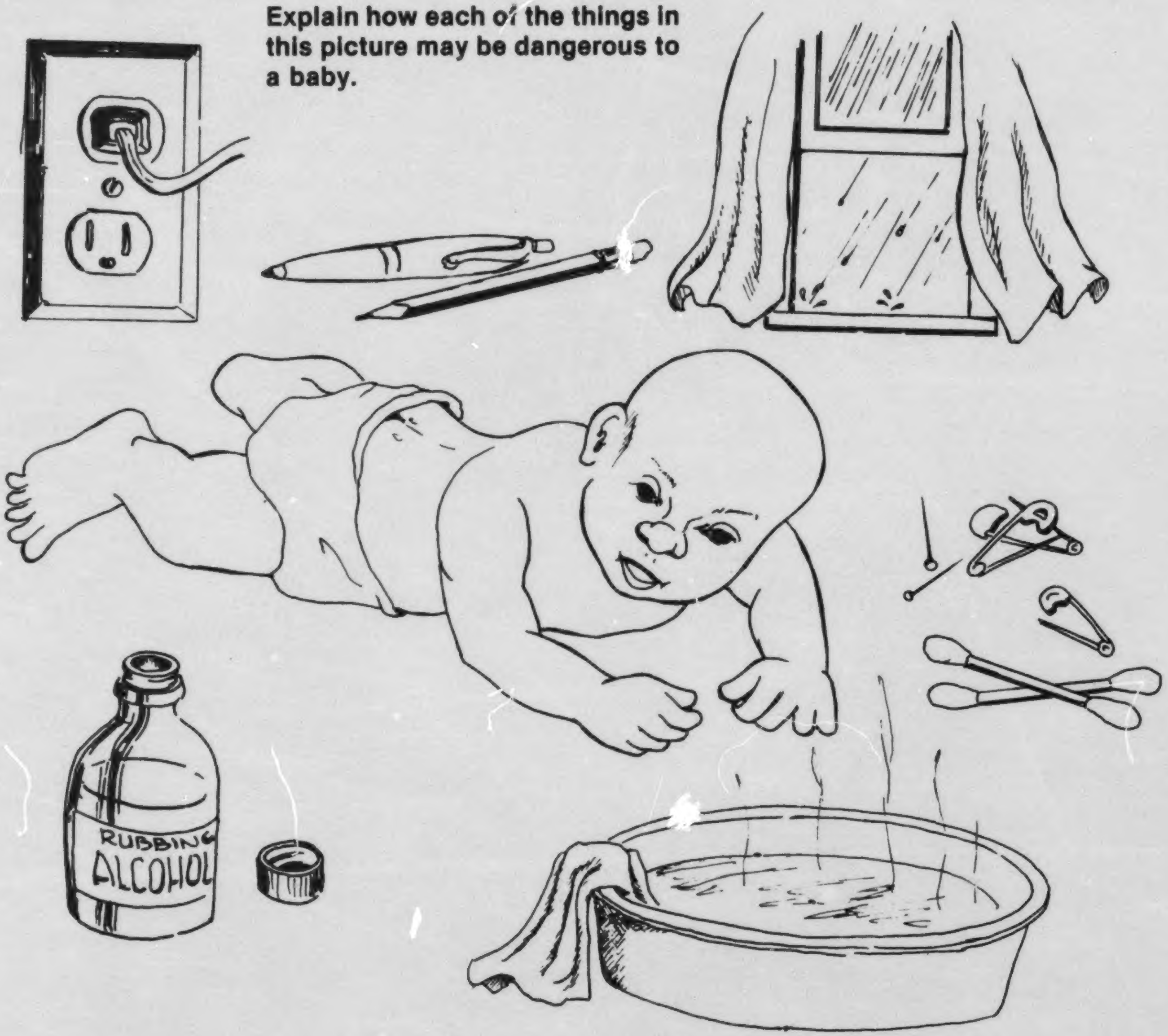
Explain how each of the things in this picture may be dangerous to a baby.



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Chapter Fourteen

"MAMA! (IS THAT ME?)"

Pages 81-84

About the Chapter

We believe that the responsibility of parenthood begins at conception. Therefore, becoming an effective parent begins with the way the expectant mother cares for herself and her unborn child.

The ability to parent effectively is no accident. Effective parenting is a process learned through the acquisition of knowledge about child development and child-care skills. Even more important, effective parenting is giving a child love, acceptance, and help. We have developed the following philosophy for effective parenthood as a basis for the education of young parents.

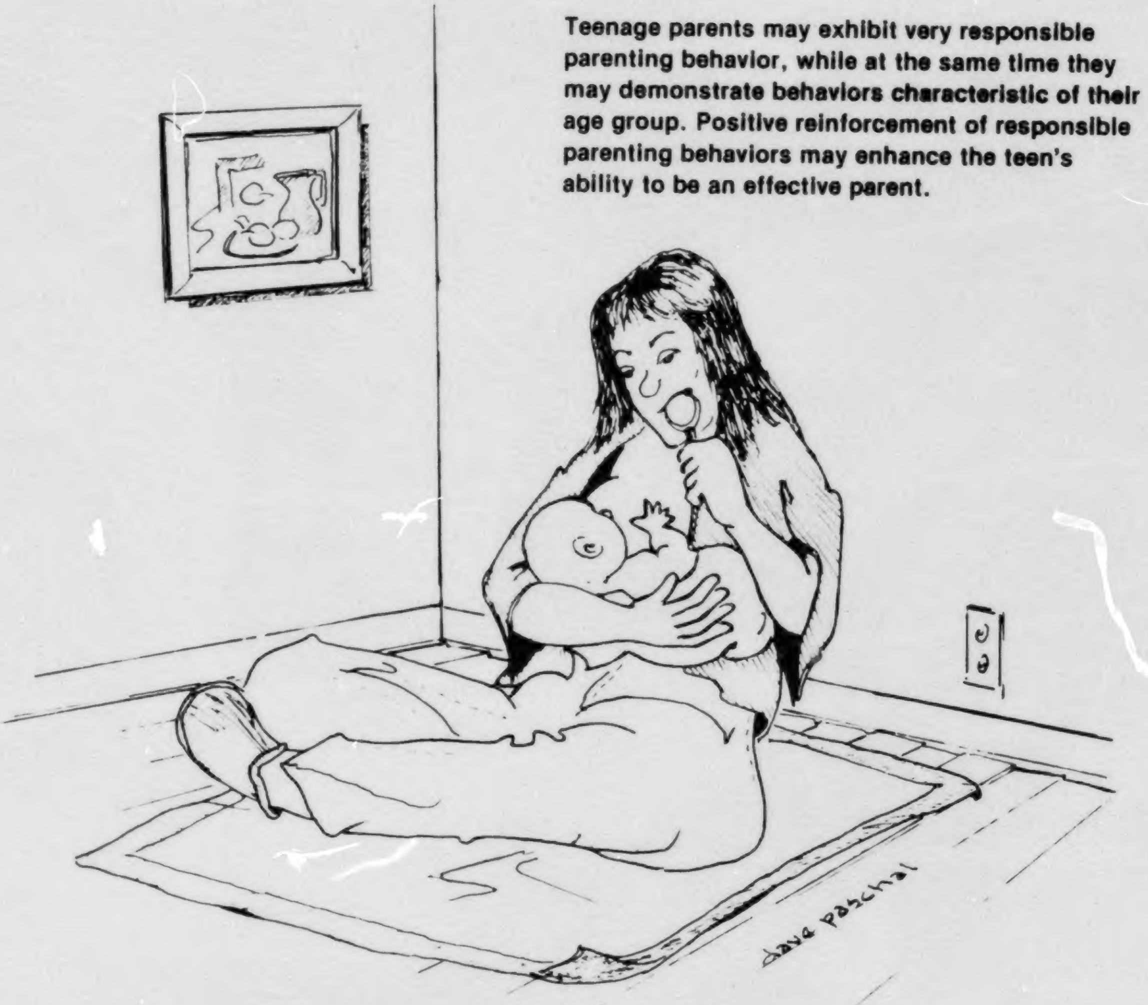
> *Learning to be a parent begins when you are a child, and it is an on-going process throughout life. The way you feel about yourself [your self-concept] influences your ability to parent. The amount of love you have to give a child depends on how much you love and respect yourself. Your ability to give is no greater than what you have. Your ability to parent will also be affected by how well you cope with the other things happening in your life.*
>
> *To become an effective parent it helps to*
>
> [1.] *have positive feelings toward yourself;*
>
> [2.] *believe you are capable of becoming the type of parent you want to be;*
>
> [3.] *evaluate the way you were parented and realize you may parent the same way unless you consciously choose to do otherwise;*
>
> [4.] *realistically understand the responsibilities of parenthood;*
>
> [5.] *understand the physical, mental, and social needs of the developing child;*
>
> [7.] *learn ways of reducing tensions and methods of coping.*

The birth of a child is a significant event in the life of any person regardless of age. For the very young mother (and perhaps her partner), the challenges are great. Those of us who work with young parents, either prenatally or during the early parenting years, are in a unique position to facilitate the formation of a positive bond between parent and child. We can be of tremendous assistance to parents in assuming their roles and in developing the self-esteem and competence necessary to parent successfully. Even though we may be with the young parent only a short length of time, the value of the support we provide should not be minimized. At the very least we are providing an opportunity for the parent-child relationship to begin on a note of success and positiveness. It is our belief that intervention can do much to prevent a spiral of negative interactions from starting.

There appears to be a prevalent myth that *once a woman has turned twenty, she is automatically ready and able to assume the role of motherhood.* The other side of that myth is that *women under the age of twenty are automatically incompetent to rear children.* (The word "automatically" is the key word here!) Like most myths there is a thread of truth in each. The error comes in taking that thread of truth and attempting to generalize it to fit everyone. As soon as that happens, we have created a set of expectations that *do not take into consideration the uniqueness of individuals.* It is our hope that those of us who are working with teenage parents will be careful not to make judgments or assumptions based on half-truths. Instead, it can be our goal to deal with each teen as an individual with a unique set of capabilities, talents, and background. From this vantage point, we can offer assistance and education appropriate to those we serve.

One of the first steps in the development of adequate parenting skills is the elevation of a young woman's sense of self-esteem. She needs the positive reinforcement of those working with her. We must be cautious that we do not unknowingly convey expectations that she will fail or that she will be somehow inadequate as a mother. Rather, it is our responsibility to reinforce her competency whenever possible.

Teenage parents may exhibit very responsible parenting behavior, while at the same time they may demonstrate behaviors characteristic of their age group. Positive reinforcement of responsible parenting behaviors may enhance the teen's ability to be an effective parent.



Young parents need to learn child-care skills. Ideally, parenting classes should provide for three levels of learning: theory, practice and personalization (see Figure 2). Theory is the basis of parenting instruction, the philosophy and basic knowledge of childrearing. The second level is practice. In this phase the young parent learns the techniques through practice. Third, and perhaps most important, is personalization. At this level the mother formulates her own concepts of childrearing. These types of learning are largely cognitive in nature.

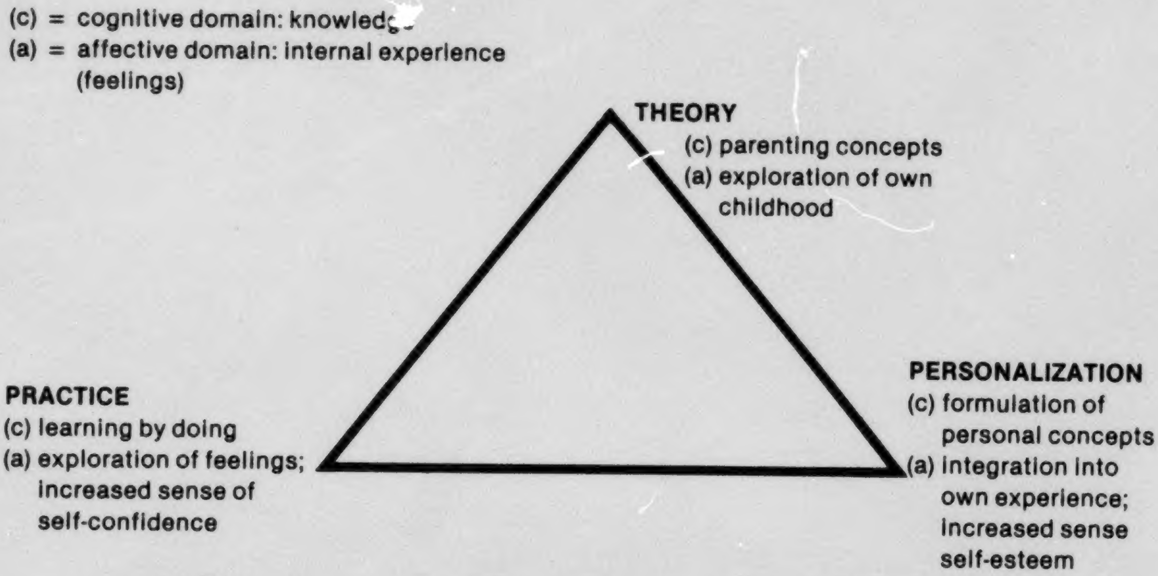
At each of these three learning levels, there is the opportunity for affective (feeling) learning as well as for cognitive learning. How does the intellectual study of parenting practices correspond to the young person's already existing internal perceptions? When teaching child-care theory, for example, it is helpful to assist the young woman with examining her feelings about her *own* experiences as a child. Did her experiences conflict with the theory she has been taught? Are there things that her parents did that were similar or significantly different? How does she *feel* about these ideas? How would she like to be different?

Affective learning takes place at the practice level as well. Child-care activities are accompanied by a whole gamut of emotional reactions. How does it *feel* to touch a child? Are there aspects of child care that are threatening or repulsive to the young mother? Is it OK with her to hold a baby and experience close physical contact? How does she feel about such intimacy? Affective learning may be enhanced by providing the young woman with models that exemplify close adult-child contact. Those of us who have the opportunity to observe the mother-child interaction must be alert to cues that indicate the need for further help in these areas.

Finally, at the personalization level, we find the affective and cognitive domains more closely integrated. The integration of parenting concepts into mothering behavior will, hopefully, be accompanied by the development of an internal sense that these parenting activities are of value. When concepts and activities are seen as valuable, the young mother gains more confidence in her ability to parent successfully. Such feelings of success then contribute to her sense of self-esteem. At the basis of all these learning levels is the importance of the rapport the young woman establishes with her teacher(s).

Figure 2

CONCEPTUAL MODEL FOR PARENTING EDUCATION


(c) = cognitive domain: knowledge
(a) = affective domain: internal experience (feelings)
THEORY
(c) parenting concepts
(a) exploration of own childhood
PRACTICE
(c) learning by doing
(a) exploration of feelings; increased sense of self-confidence
PERSONALIZATION
(c) formulation of personal concepts
(a) integration into own experience; increased sense self-esteem

The three major components of effective parenting education are theory, practice, and personalization. The ultimate goal is the integration of these concepts into personal behavior and the internalization of these concepts into the value system. This process is facilitated by mutual trust and warm regard between teacher and student.

Developed by Catherine Monserrat and Linda Barr

Evaluating the Mother-Child Relationship

There is widespread concern that teenage parents tend to be more abusive and neglectful than the rest of the parent population. As of this writing, we have seen *no* research evidence that this negative evaluation is justified. Child abusive behavior sometimes results from emotional immaturity, feelings of inadequacy, abusive family background, and other stress factors. Because of the additional stress teen parents may face and because some teen parents may come from abusive homes themselves, the professional who works with these young people may want to be alert for signs of potential neglectful behaviors.

In your interviews with a young mother, ascertain how well she herself is being nurtured. Does she have a supporting person in her life upon whom she can depend? The young parent who is completely alone and faced with confinement may have difficulty coping with the stresses of parenting. Her needs for money, transportation, and day care may further contribute to her level of stress and her sense of frustration.

The mother's interactions with her child can provide further cues. When the relationship is positive, the mother will hold her baby close, touch him lovingly, and talk to him in a soothing voice. If there are problems in the mother-child relationship, the mother may handle the child roughly, avoid eye contact, and show other signs of avoidance.

Some mothers express excessive concerns about their children. If a mother *repeatedly* reports difficulties with the child's behavior, health, eating habits, or "discipline," she may be crying for help and assistance. The helping person may be tempted simply to discount her concerns and tell her that the baby is fine. Whenever possible, take time to discuss these concerns with the young mother and to ask her to elaborate on her interactions with her child. Her descriptions of her daily interactions with the child can provide clues to her feelings and frustrations.

Another factor to consider may be her experience with pregnancy, labor, and delivery. If the young mother suffered the rejection of her family, boyfriend, and/or other friends during pregnancy, she may have some resentment toward her child. An extremely difficult labor or otherwise unpleasant birthing experience may also have some effect on the mother-child relationship.

The mother-child relationship may be either facilitated or hampered by the presence of the young woman's own mother or other adult. If the adult assumes a supportive role, offering the young mother praise and encouragement of her mothering ability, her self-esteem tends to elevate. If, on the other hand, the adult points out the young mother's inadequacies verbally or if the adult takes over, the young mother's sense of adequacy is diminished and the bonding hampered.

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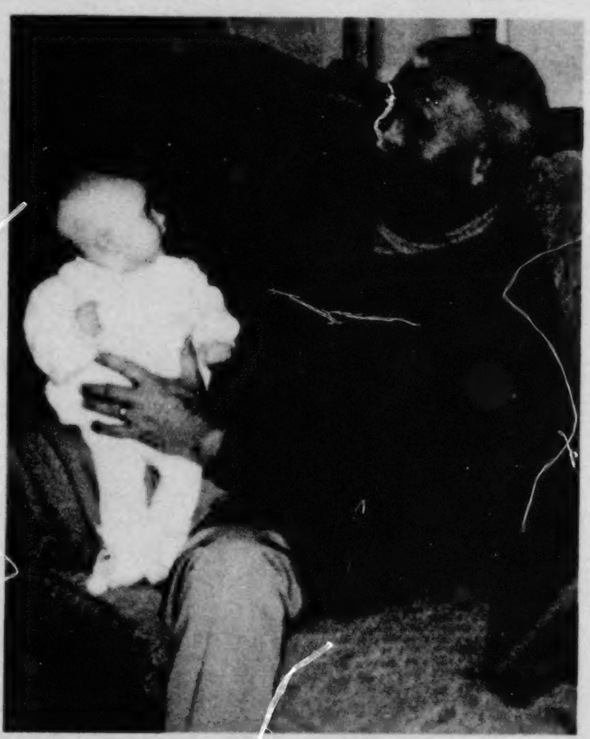
At the end of this chapter, we have included three simple tools for your use in assessing the mother's relationship with her child. The first section of this "Parenting Profile" includes basic topics that you may want to discuss with her privately. The second part provides a list of factors you can ascertain through observation. The final component consists of a series of questions to assist the young mother in reflecting on her relationship with her child. You may want to discuss the answers with the young mother. If through your discussions and observations you feel the young mother to be at risk, we strongly recommend action. If your own agency does not have counseling available, seek help from other resources.

Developing Support Systems

The value of familial support cannot be overemphasized. In addition to the young woman's mother, the other family members are often able to provide the support and assistance the young mother needs to reach her goals and to provide a healthy environment for her child. The age and sex of the supportive individual seem to be far less important than a sincere interest, a caring attitude, and the capability of offering assistance. In some cases a grandparent or great-grandparent has the time and energy to provide valuable assistance with childrearing. The attachments formed can be extremely valuable for the developing child and for the nurturing grandparent, in addition to providing help to the young mother.



Parent support groups provide another effective means of helping young women gain confidence in their parenting roles. In these groups young mothers can share the joys and frustrations they experience as new mothers. Group members can offer suggestions on coping techniques as well as give support to one another. Parent support groups also help to alleviate the feelings of social isolation often experienced by teen parents.

Coping with feelings of anger, frustration, and tension is often difficult for young mothers. In the student text we have offered some suggestions on effective, safe ways to release these feelings. You may need to encourage young mothers to *try* some of the techniques suggested as they may feel they are silly and may be embarrassed to do them. One effective method of coping with negative feelings is to take time out to be alone or to be with friends. Time out may be impossible for many young mothers who do not have anyone to take care of their babies. Young mothers can offer one another support through reciprocal babysitting arrangements. Such support can be extremely helpful when money is not available for baby sitters. If young mothers can't offer babysitting for each other, they can call each other on the phone and provide support. Another suggestion is to organize a "Mother's Day Out" program with volunteers to take care of the children.

Frustration often comes from inadequate financial resources. You might provide support by having equipment available for loan. If your program has space available for storage, you can solicit donations of strollers and other play equipment. We encourage you to work with young parents to devise other creative methods of coping.

I. Chapter Goals
- A. To encourage the development of a happy and confident attitude toward parenting
- B. To encourage the young mother to develop an attitude of acceptance of herself and her child
- C. To help the young mother realistically understand and accept the responsibilities of parenthood
- D. To help the young mother be realistic about what she expects from her child
- E. To provide simple tools for coping with tensions and unexpected feelings

II. Important Concepts
- A. The effectiveness of a parent is directly related to his/her self-concept.
- B. Parenting behavior is influenced by cultural and societal standards and practices.
- C. The way in which an individual was parented is usually reflected in his/her own parenting practices.
- D. Learning constructive measures for the release of tension and anger may be helpful in reducing child abusive behaviors.

III. Learning Objectives

The student will be able to do the following:
- A. List and discuss four factors that can have a positive influence on one's effectiveness as a parent;
- B. List four constructive methods by which one can release feelings of tension and/or anger;
- C. Describe from her own childhood experiences the way in which she was parented and describe how she perceives her own role as a parent;
- D. List three factors to consider when choosing someone to care for an infant.

IV. Content Overview

Text Page

- A. To become a good parent, it helps to 81-83
  1. Feel good about oneself,
  2. Believe in oneself,
  3. Understand that parenting attitudes and practices are first learned from one's own parents,
  4. Accept the responsibilities of parenthood,
  5. Formulate realistic expectations of oneself and the child,
  6. Learn constructive methods of coping with tension and anger.
- B. Maternal instinct 83
- C. Helpful hints for new parents 83
- D. Fathers 84
- E. Grandmothers 84
- F. Others 84

V. Suggested Learning Activities
- A. Make a list of 20 things the students *like* about themselves (physical characteristics, personality traits, talents, etc.)
- B. Make a poster depicting the mother's responsibilities to her child.
- C. List in order of importance the qualities a parent should have. Share the lists in pairs and share what each feels is most important. As a group, discuss the list. This is an excellent opportunity to bring out that differences in parenting practices exist and are *OK!*' (originally designed by Sidney Simon.)
- D. Have students explore their experiences as children and discuss how they would like to be like/different from their own parents. (NOTE: Students who have themselves been abused either physically or emotionally may be fearful of repeating that behavior with their own children. They may or may not approach you with this information. If they do, encourage them to formulate alternative methods of coping and provide them with appropriate referral.)
- E. Role-play the handling of various situations related to child care (examples: crying baby at 2 a.m., baby pulling things off tables, potty training, etc.) Discuss feelings and ways of handling the situations.
- F. Role-play giving praise and positive criticism versus negative or destructive criticism.
- G. Report on what a child can be expected to learn at various stages of development. Discuss variations in rate of development.
- H. Discuss methods of releasing tension and/or anger. Decide which are constructive and which are destructive (to self or others).
- I. View films/filmstrips on children and parenting.
- J. Visit a day-care center or nursery to assess adequacy of care, costs, etc.

K. Read the IALAC (see resource list) story to students and discuss how one's sense of self-worth is damaged by negative criticisms and interactions. Solicit examples and discuss, encouraging positive interactions among students.

L. Discuss the differences between discipline and punishment. Assist students in exploring the alternative methods of discipline and appropriateness for various ages.

M. Invite a social worker or counselor to speak on child abuse and the resources available.

N. Invite a counselor or psychologist to speak on the development of a positive self-concept.

O. Invite a speaker from a day-care center to to talk about available facilities, types of care, costs, etc.

P. Discuss or answer in writing the questions in part VI.

VI. Questions for Discussion/Study Guide

A. How can feeling good about yourself help you become a good parent?

B. Describe the kind of parent you want to be.

C. What are the responsibilities of being a parent?

D. What happens if you try to teach a child something before he is ready to learn it?

E. What are some helpful things you can do when
   1. You are tense (list three)?
   2. You are angry (list three)?

F. Think back on your own childhood and how you were treated.
   1. List three ways you want to be like your own parents.
   2. List three ways you want to be different when raising your own child.

G. What advice would you give a new parent? Name three helpful hints.

H. List three things to look for when you choose someone to take care of your baby.

VII. Resource Materials

A. Films on child development and parenting:
   1. *Abby's First Two Years, a Backward Look*
   2. *Adapting to Parenthood*
   3. *Childhood, the Enchanted Years*
   4. *Parenting Concerns: The First Two Years*

B. Films on the sex education of children:
   1. *Birds, Bees, and Stork*
   2. *A Family Talks About Sex*
   3. *Old Enough to Know*
   4. *Parent to Child About Sex*

C. Filmstrip/Cassette: *Parents' Magazine Series*

D. Pamphlets:
   1. *Becoming a Parent*, Ross
   2. *Developing Self Esteem*, Ross
   3. *Developing Toilet Habits*, Ross
   4. *Discovering Parenthood*, Ross
   5. *Feelings of Conflict in New Parents*, Ross
   6. *How Your Child Learns About Sex*, Ross
   7. *PMIC Materials on the Positive Parent*, Parenting Materials Information Center
   8. *When Your Child is Unruly*, Ross
   9. *Your Baby Becomes a Toddler*, Ross
   10. *Your Children and Discipline*, Ross
   11. *Your Child's Appetite*, Ross
   12. *Your Child's Fears*, Ross
   13. *Your Child's Potential to Learn*, Channing Bete, Co.

E. Books:
   1. *Between Parent and Child*, Ginott
   2. *Discipline*, Keister
   3. *"I Am Loveable and Capable"* (IALAC), Simon
   4. *Mother Care*, Quadri and Breckenridge
   5. *The Mother's Guide to Child Safety*, Kalt and Bass
   6. *Non-Sexist Childraising*, Carmichael
   7. *The Parent Book: The Holistic Program for Raising the Emotionally Mature Child*, Bessell and Kelly
   8. *Parenting, a Guide for Young People*, Gordon and Wollin
   9. *Parenting Preschoolers: Curriculum Help and Study Guides* (teachers) and *Parenting Preschoolers: Study Guides for Child Care Books* (student manual), Lindsay
   10. *Raising Happy, Healthy Children*, Olness
   11. *The Single Parent Experience*, Klein
   12. *Survival Handbook for Preschool Mothers*, Smith
   13. *What to Do When There's Nothing to Do*, Gregg
   14. *You*, Gordon

PARENTING PROFILE: A tool for evaluating the mother-child relationship

Part I:

DISCUSSION

Home situation:

Support/assistance with child care:

Relationships (family, husband, boyfriend):

Feelings about the pregnancy? Labor? Delivery?

Mother-child relationship:
  What is positive?
  What is negative?
  Time together? Fun?
  Crying?
  Feeding?
  Handling everyday situation? Who has control?

Concerns about the child?
  Difficulties
  "Discipline"
  Health
  Behavior
  Complaints

Remarks:

Part II:

OBSERVATION

Verbalizations to infant:

Physical handling:

Verbalizations about infant to others:

Expectations for child's performance:

Eye contact:

Touching:

Comfort of distressed child:

Reactions when others show interest:

Complaints about child, parenthood, etc.

Part III:

SELF-AWARENESS QUESTIONS FOR THE YOUNG PARENT

1. What do you like most about your baby?

2. When do you feel the most love for your child?

3. How do you show your love?
   Are you satisfied with the ways you show your love?

4. When do you feel the most upset with the baby?

5. How do you show you are angry or upset?
   Are you satisfied with the ways you show anger or upset?

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Chapter Fifteen
"FAMILY PLANNING: IS IT FOR YOU?"
Pages 85-91

About the Chapter

The discussion of family planning and methods of birth control can be very enjoyable for both teachers and students. The creation of a relaxed, accepting atmosphere is essential. As with other sensitive topics, be prepared for personal questions. Your students may ask you about your own contraceptive practices and preferences. They may seek out *your* values related to family planning, religious issues, and family size. Your nonverbal responses will give you away and may have more influence on their choices than you might think. It is best to decide ahead of time how you will respond to their questions; attempt also to become aware of your own biases.

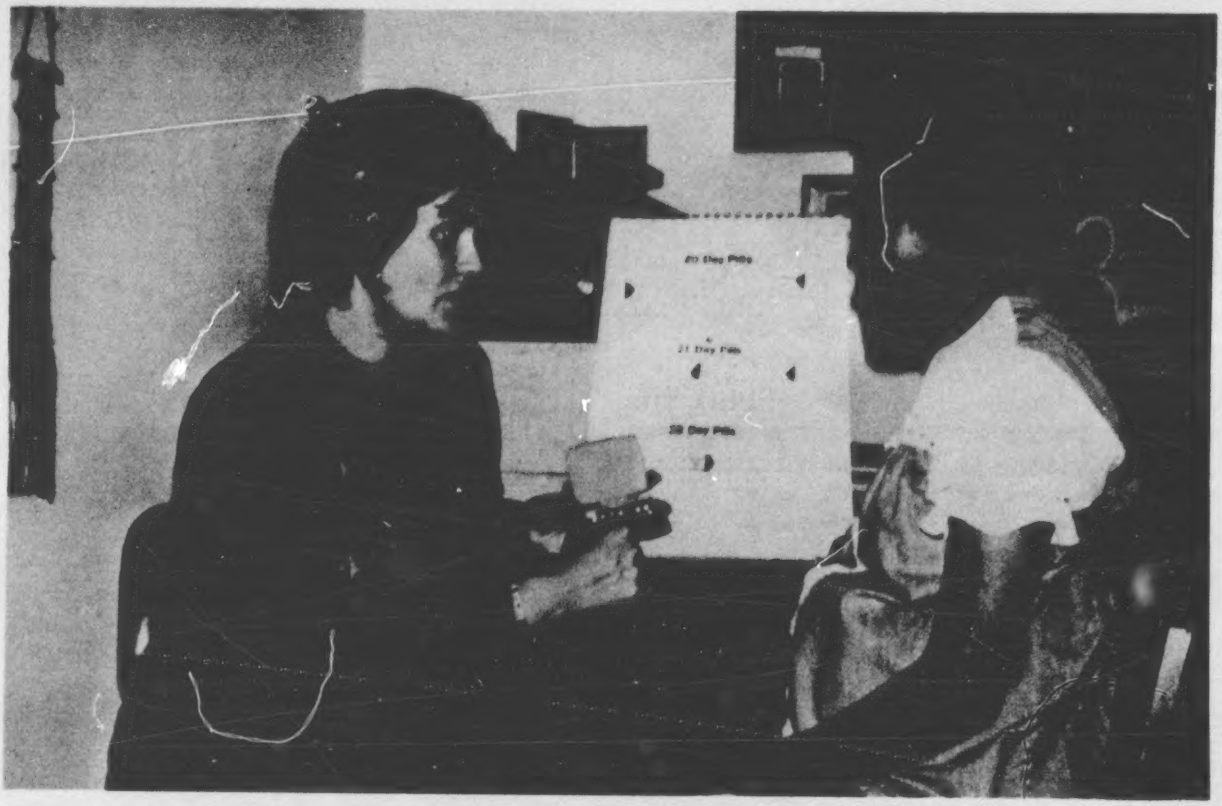
It is particularly important for you to be aware of your biases regarding contraception. For example, how do you feel about teenagers using birth control? Do you feel that all teens who have been pregnant *should* contracept? Do you believe that teenagers who have had sex are capable of choosing abstinence? Do you feel strongly about a young woman having another pregnancy during teen years? These questions are highly controversial and value-ridden. You probably *do* have some strong feelings about these issues. These feelings will influence your effectiveness in dealing with this topic. Your awareness of your feelings and biases will allow you to make *conscious* choices about the degree to which they will influence your discussions of family planning and birth control.

Many people believe strongly that contraception is appropriate for everyone. Others feel just as strongly that contraception is immoral. There is a wide range of attitudes that fall somewhere between these two positions. When discussing family planning with young people, remember that it may not be a choice that is acceptable to everyone.

There are many factors that have a strong influence on one's decision. These include the individual's life goals, personal situation, and health factors, as well as cultural, religious, and familial beliefs. In the first part of this chapter, we have enumerated questions related to each of these areas. All of these will have an effect on an individual's decision about whether or not to space children. These lists have been offered as a basis for the student's development of personal awareness of her own preferences related to each topic. It is *not* your responsibility to answer these questions for the young person. It *is* your responsibility to provide factual information and a comfortable atmosphere in which the young person can formulate her own answers and clarify her position.

Another significant influence on the individual's decision may be her maturational level. The normal, healthy adolescent tends to be a risk taker, an experimenter, and an individual primarily oriented to the present. In addition, there is the influence of the media, which creates a set of expectations related to sexuality. Peers, too, may have a primary effect on the teenager's contraceptive behavior.

These maturational influences are often coupled with strong desires for intimacy, a sense of femininity, independence from parents, and perhaps an unconscious wish for a child. All of these factors exert an influence on a young woman's decision about whether or not to contracept. These same factors also influence how effectively she will use a contraceptive method.



In your discussions it is not enough to explain birth control methods. It is also important to explore motivations for planning and spacing children. Some people like to include a discussion of population considerations. The concept of world overpopulation may be a difficult topic for young women to relate to. They may experience feelings of guilt or anxiety because they are *already* pregnant.

In our experience the factors that influence motivation to plan pregnancies are those that are more personal to the young woman. Teenagers can relate to physical and emotional factors, loss of personal freedom, and financial and educational implications of frequent pregnancies. They also can relate to concerns for the well-being of their children. To many, parenting education is considered to be a primary component of family planning.

Throughout this guide we have emphasized the importance of assisting the young parent to develop self-confidence and a positive self-image. This concept is no less important in the family planning area. The young person's ability to follow through with her decision to use a method of contraception is closely related to her self-confidence and to her belief that she can exercise control over her life experiences. As you interact with this young person, everything that you do to enhance her self-confidence and her belief in a better future contributes to her ability to follow through with her decisions regarding family planning as well as her decisions regarding parenting, education, and other vital areas of her life. The reverse, unfortunately, is also true.

In the student text the chapter contains the *basics* of contraceptive methods. We have intentionally avoided listing too many "advantages," "disadvantages," and "side effects." Without supporting discussion, too much written data can be confusing or frightening. However, questions regarding these side effects will arise; and such discussions can be both clarifying and reassuring. The "side effects" of pregnancy may be weighed against the risk of contraception.

New information related to contraceptive technology is continually being released. For this reason we are not going to attempt to provide such supplemental information here. What is current today may be obsolete tomorrow! We strongly urge you to keep current on the latest information. Agencies such as family planning clinics often have access to recent data on contraception and may be good resources for audio-visual and written materials. Many of these agencies will provide speakers to talk to classes and other small groups.

A basic unit can be effectively taught with a few good audio-visuals and samples of contraceptive devices. There are several good, simple-to-understand flip charts. These are particularly effective because you can speak in a language the students understand. You can point out things in the pictures and answer questions as they arise. Movies are good too, but for effective learning a thorough discussion should follow every film. Be sure that the films are up-to-date and are acceptable in your setting.

If the young people with whom you are working are *still* pregnant, they may not fully absorb contraceptive instruction because it is not pertinent to them at the moment. Individual sessions following delivery may prove to be more effective when pregnancy is again a possibility. In these individual sessions, you have the opportunity to discuss the factors that may influence the young woman's decision. There are several questions to explore with her. Does she have a steady boyfriend? Is she dating at all? Does she *believe* she will be sexually active? What are her feelings about having more children right away? Are there familial, religious, or social issues affecting her decision?

If the young woman makes the decision to contracept, a discussion of the methods is then appropriate. In addition to how and why the various methods work, you may wish to discuss the young woman's feelings about each one. If she chooses a method that she doesn't like or doesn't trust, she is less likely to use it properly and effectively. If the young woman feels good about her choice, fully understands how it works and how to use it, and wants to plan her childbearing, she is more likely to use her method effectively.

As a basis for any discussion of birth control methods, an understanding of the process of conception and the timing of ovulation are essential. You will notice in the student text that we have avoided using such terms as "most effective" and "least effective" when describing birth control methods, as effectiveness is closely related to the individual's own choices and motivations.

The following is supplementary information which you may find helpful.

Pill

Some teenagers tend to go on and off the pill according to whether or not they have a boyfriend. Such erratic use of the oral contraceptive may result in an unexpected pregnancy. Other teens will not use the pill because they are afraid their mothers will find them. Encourage discussion of these factors as they definitely influence choices.

I.U.D.

One of the "advantages" of the I.U.D. is the fact that no one but the woman herself needs to be aware of its presence. Cases in which the woman desires to contracept and her parents object can be discussed. Though we realize that there are different theories as to how the I.U.D. prevents pregnancy, we have chosen to omit them since they are not considered conclusive.

Diaphragm

Because the diaphragm may not prevent all sperm from reaching the cervix, contraceptive cream or jelly must always be used with the diaphragm.

Condom

Many teenage girls are reluctant to ask their partners to share in the responsibility for contraception. Your students may mention this reluctance when you discuss the condom with them.

Foam

In addition to its spermicidal action, foam also blocks the opening to the uterus. Anything that removes or diminishes this chemical barrier can greatly decrease its effectiveness! Examples of how foam can lose its effectiveness include running to the telephone or waiting too long to have sex after putting in foam. Remind students that foam is the method doctors often recommend during the four to six weeks following delivery or during the time of breastfeeding. Foam is most effective when used with the condom.

Natural Family Planning Methods

The effective use of natural methods depends upon how well trained a woman is and how motivated she is to do what is required of her. A teen may find it difficult to use natural family planning methods successfully because of the irregularity of her menstrual cycle and the difficulty of detecting body changes. Since abstinence will be required during certain parts of the cycle, the young woman may have difficulty obtaining the cooperation of her partner. If a teenager chooses a natural family planning method, she will need to consult a family planning counselor or doctor for complete information.

Methods That Don't Work

The list in the book contains the misconceptions most commonly contributed by our students. There are probably many more. Have your students share what they've heard.

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I. Chapter Goals
  - A. To help explore various personal and cultural considerations as a basis for making decisions about family planning
  - B. To provide information about the various birth control methods, their use and availability
  - C. To dispel misinformation about conception and contraception

II. Important Concepts
  - A. Personal values, knowledge, religion, cultural beliefs, and peer and societal pressure influence decisions related to family planning.
  - B. Knowledge of available methods of birth control is essential to the ability to plan and space pregnancies.
  - C. The "most effective" contraceptive method is the one the individual will use.

III. Learning Objectives

The student will be able to do the following:
  - A. Define family planning;
  - B. List five things to consider when deciding whether or not to plan one's family;
  - C. Name three methods of birth control that require a doctor's examination and prescription;
  - D. Name two methods of birth control that can be used without a doctor's prescription;
  - E. Name four *unreliable* methods of birth control;
  - F. Explain how each of the following methods of birth control acts to prevent pregnancy: birth control pill, I.U.D., diaphragm, foam, and condom;
  - G. Explain how the methods listed above are correctly used;
  - H. List two of the advantages and disadvantages of each of the methods of birth control named above;
  - I. List four considerations in choosing a method of birth control.

IV. Content Overview

Text Page
  - A. Family planning defined 85
  - B. Considerations related to family planning 85, 86
    - 1. Personal goals
    - 2. Life situation
    - 3. Physical and emotional health (of both parents and children)
    - 4. Cultural beliefs and attitudes
    - 5. Religious beliefs
  - C. Conception reviewed 86
  - D. Pill 87
    - 1. Prevents ovulation
    - 2. Requires doctor's prescription
    - 3. Is to be taken daily at the same time
    - 4. Has advantages and disadvantages
  - E. Intrauterine device (I.U.D.)............. 88
    - 1. Requires insertion by a trained health care specialist
    - 2. Requires checking of threads from I.U.D. in vagina after each period
    - 3. Has advantages and disadvantages
  - F. Diaphragm.......................... 89
    - 1. Covers opening to cervix, preventing sperm from entering
    - 2. Requires measurement by and a prescription from a trained health care specialist
    - 3. Must always be used with a spermicidal jelly
    - 4. Is inserted prior to intercourse and left in place for at least eight hours
    - 5. Has advantages and disadvantages
  - G. Condom 90
    - 1. Covers the penis preventing sperm from reaching egg
    - 2. Does not require a doctor's prescription
    - 3. Is placed on erect penis before it enters vagina
    - 4. Helps prevent spread of V.D.
    - 5. Has advantages and disadvantages
  - H. Foam, jelly or cream 90
    - 1. Kills and/or blocks sperm from entering the cervix
    - 2. Does not require a doctor's prescription
    - 3. Must be used before *each* act of intercourse by placing it into the vagina
    - 4. Has advantages and disadvantages
  - I. Natural family planning methods...... 91
    - 1. Abstinence from sexual intercourse during a woman's fertile period
    - 2. Four types based on a woman's awareness of her fertility cycle
    - 3. Special help required from a trained health care specialist
  - J. Questions to consider when choosing a method................... 91
  - K. Methods that will not work............ 91

V. Suggested Learning Activities
  - A. View films and filmstrips on family planning and birth control.
  - B. Bring in articles from newspapers or magazines related to birth control.

C. Talk to clergymen and report on religious attitudes about contraception. Share findings.
D. Debate on the topic of whether or not people "should" plan their families.
E. Take a poll of the class as to how many children each student wants. Discuss differences in values and reasons for preferences.
F. Report on the history of birth control.
G. Invite a doctor or family planning counselor to talk about birth control methods.
H. Visit a drugstore and report on availability and costs of various methods of contraception.
I. Visit a family planning clinic.
J. Discuss or answer in writing the questions in part VI.

VI. Questions for Discussion/Study Guide
   A. Define family planning.
   B. List five things to think about when deciding whether or not to plan your family.
   C. Name three methods of birth control that are prescribed by a doctor.
   D. Name two methods of birth control you can use *without* a doctor's prescription.
   E. List six things that will *not* keep you from getting pregnant.
   F. List four things you will need to think about when deciding which method would be right for you.
   G. Complete the following chart:

	Method of Birth Control				
	Pill	IUD	Diaphragm	Foam	Condom
How Does It Work?					
What Do You Have To Do To Use It Correctly?					
Advantages					
Disadvantages					

VII. Resource Materials
   A. Films on family planning and/or birth control:
      1. *About Conception and Contraception*
      2. *Birth Control: The Choices*
      3. *Contraception: Yesterday and Today*
      4. *Hope Is Not a Method*
      5. *To Plan Your Family*
   B. Films on population concerns:
      1. *Tomorrow's Children*
      2. *Under One Roof*
   C. Films on sexual decision making:
      1. *How About You?*
      2. *Teen Sexuality: What's Right for You?*
   D. Chart and demonstration kit: Pelvic model and birth control demonstration kit (Ortho)
   E. Pamphlets:
      1. *Am I Parent Material?*, National Organization for Non-Parents
      2. *Birth Control, All the Methods That Work and the Ones That Don't*, Planned Parenthood of New York
      3. *Catalog of Family Planning Materials*, DHEW (HSA) 79-5606
      4. *Decisions About Sex*, Planned Parenthood of Westchester
      5. *The Extra Advantages of Family Planning*, DHEW (HSA) 75-16012
      6. *He Doesn't Need a Prescription to Get Birth Control That Works, Neither Does She, Neither Do You*, Planned Parenthood of New York
      7. *Improving Family Planning Services for Teenagers*, DHEW-391
      8. *The Pill, the Diaphragm, the IUD*, Planned Parenthood of New York
      9. *What's Happening Now*, Emory University
   F. Books:
      1. *Contraception: A Planned Instruction Mini Unit*, Planned Parenthood of Central Pennsylvania
      2. *Contraceptive Technology 1980-81*, Hatcher, et. al
      3. *A Guide to Values Clarification in Sex Education*, Dumont
      4. *Sex Is Never an Emergency*, Pierson
      5. *Values and Sexuality, a New Approach to Sex Education*, Morrison
   G. Article: "A New Way to Teach Teens About Contraceptives," Taylor

Chapter Sixteen

"FOR THE FATHER OF THE BABY"

Pages 92-93

About the Chapter

The two pages in this chapter are for the father of the baby. It was not our intention that this chapter be used as a teaching unit. We realize that many young men are involved in the lives of their girlfriends and/or wives and do have an interest in what pregnancy and parenting involve. However, the following quotes from our students indicate why our approach to adolescent childbearing and childrearing has been primarily female centered.

> This last year all I ever seem to feel is loneliness and depression. A lot of times I can be with ten other people and still feel terribly alone. There's something missing. It could be not being married or even having a boyfriend. All the others talk about 'him' all the time. That's the time it hurts the most!

> To be safe, be gentle and careful when talking about guys. Mentioning a boyfriend may cause some girls to cry or be hateful. Some may be eager to talk about him. Who knows? Usually that's a dangerous subject, but carefully done I guess a person can find out without causing much upset.

If you work with young fathers, you can have them read the chapter and discuss their feelings about its content. As suggested in the student text, young fathers may be interested in reading the entire book or certain chapters. Our students have indicated that their boyfriends and/or husbands have frequently enjoyed reading the text. A young couple can feel closer as they share with each other what they have learned about a very important aspect of their lives — becoming parents.

We have not followed the usual lesson plan format in outlining this chapter. Instead we have included a narrative written by Lee Protomastro, a male counselor at New Futures School who has worked extensively with young fathers.

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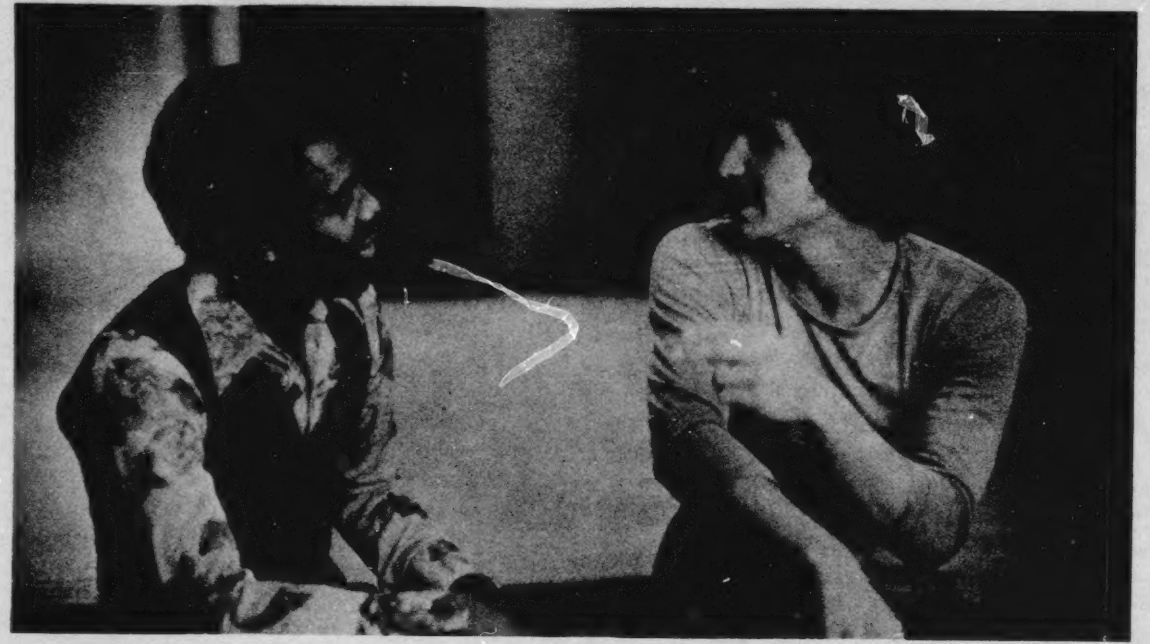


YOUNG FATHERS

by Lee Protomastro

Our society's growing recognition of the lack of effective programs for young fathers has given rise to a serious concern for a re-evaluation of the position of the young man in the teenage pregnancy picture. Contrary to popular belief, the young father has usually been involved in a relationship of some duration with the girl and in most instances sincerely cares for her. The majority of these young men continue their relationships throughout pregnancy, and they make serious efforts to help their partners and to be good "fathers." Failure in these efforts is usually the result of a series of complex circumstances.

In this age of rapidly shifting social ideas and values, "father" is still defined as the guy who impregnates the woman, pays the bills, makes the decisions, fixes the faucets, and in general carries out the more impersonal aspects of parenthood. The adolescent male is heir to this. Change has been slow, doing little to eliminate his doubts, confusion, and uncertainties. Most young men continue to find themselves feeling awkward or uncertain about what is actually expected of them, how to go about becoming an involved partner, and how to express their emotions effectively. Too often their efforts result in a sense of personal inadequacy and in the disillusionment of their partners. Immaturity and lack of preparation for this new role may easily result in a fine person being considered a poor "father."

The underlying problems are not difficult to discover. Our young people are entering into sexual intimacy earlier in life due, at least in part, to an earlier physical sexual development and shifting, unclear standards of morality. The abundance of sexual stimulation offered in today's society has once again proven itself to be an agonizing trap with few if any ways of escape. The increased instability of family life provides a minimum of support while bequeathing an incomprehensible idea of male-female relationships. A young man leaving high school may realize that he is bound by many false ideas about "masculinity," an impersonal concept of relationship, and no foundation upon which to build his values and goals. How does he meet with the inevitable questions of life:

What does it entail to be a companion to a woman?

How does one share a life?

What is involved in being a partner in a household?

How does one person listen to another and communicate in return one's own needs and desires?

Is it possible to console when there is no apparent solution to a problem?

The sudden transition from the "play" world of school and personal freedom to the harsh reality of the job market is traumatic for many a young man who discovers he is either unwilling or unable to sustain employment and bear the pressures of financial responsibility. The youthful male's childhood of impersonal toys and games

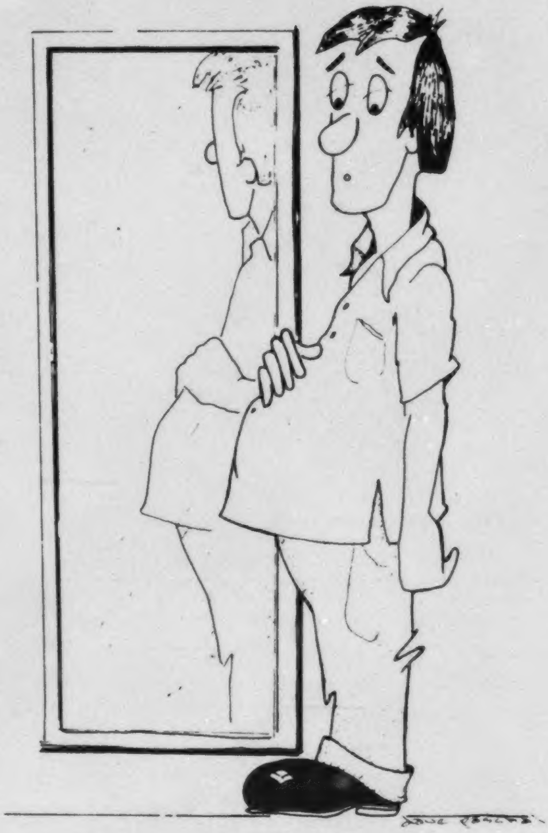
evolves into a world of automobiles, sports, drinking, and fun that bears no resemblance to the responsibilities fatherhood suddenly thrusts upon him. Friends, whom one would expect to provide support and understanding, may be sources of further frustration, contributing to the deterioration of an already difficult situation.

Seen in the perspective of this complex picture, even the most gifted, loving, and mature young man faces a difficult task. No one should be shocked that the relationships and marriages of these young couples do not survive for too many years after the birth of their children.

Our personal experience is that good will and strenuous effort do make for some progress with individual young fathers. Though few young men accompany their pregnant partners to enroll in New Futures School or to visit afterwards, we are able to make contact with many of them. A number attend our evening "couples night" programs. We establish contact with the young men by working with and through their partners, giving them the needed encouragement and support.

These evening programs, offered each quarter during the school year, consist of a series of three or four weekly meetings. Discussion topics include the physical and emotional aspects of pregnancy, male-female relationships, the effects of parenthood on the couple relationship, etc. Both audio-visual material and group discussion are utilized to expand on the topics. We have found this to be the best method of contact, imparting information, and establishing an initial rapport that provide the basis for future counseling. Many young fathers tend to be quite silent at first, but they listen intently. The girls report greater openness and understanding in their subsequent communication. Part of the success of these programs is due to recalling clearly the importance of the individual young man and stressing that he, the young woman, and the baby must *each* receive due consideration.

The nation's educational system is just beginning to implement long-needed modifications regarding sex education and preparation for students' future lives. Until our society in *all* its elements (family, school, government, etc.) begins to provide more realistic preparation for all young people, we will continue to find them inadequately prepared for the responsibilities of adult life. The great needs and demands of the pregnant girl, as well as the young man's own needs for personal growth and development, are tremendous challenges for **many a caring young man whom a whole world now calls "father"!**

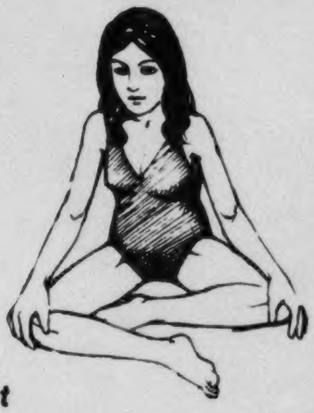


Resource Materials

- **A.** Film: *Teenage Father*
- **B.** Slides/Cassette: *The Nurturing Father*
- **C.** Books:
  1. *Father Journal: Five Years of Awakening to Fatherhood,* Steinberg
  2. *The Unmarried Father,* Pannor
- **D.** Articles:
  1. "Probabilities of Intercourse and Conception Among U.S. Teenage Women," Zelnik, et al.
  2. "Sexual and Contraceptive Knowledge, Attitudes, and Behavior of Male Adolescents," Finkel and Finkel
  3. "The Unmarried Father, Revisited," Pannor and Evans
  4. "Unwed Teenage Fathers: A Preliminary Report on Emotional and Health Educational Needs," Elster and Panzarine

"EXERCISE BOOKLET"

14 Pages



About the Booklet

The Exercise Booklet includes exercises for perinatal muscle strengthening, relaxation, labor and delivery, and the regaining of muscle tone following delivery. The suggested exercises were selected because they are appropriate for the pregnant teen, are easy to learn, and are generally accepted by the medical profession. Because the pregnant teen may not have a coach with her during labor and delivery, we have selected breathing techniques that can be easily done by a young woman who is alone.

In addition to preparing a woman for labor and delivery, regular exercise is valuable for the alleviation of many common discomforts experienced during pregnancy. Postpartum exercises are valuable for a normal recovery and for a sense of emotional and physical well-being. In fact, a pattern of regular physical exercise has been shown to enhance physical and emotional stability throughout life.

We have been very cautious in the selection of postpartum exercises due to the widespread disagreement as to type and appropriateness of some exercises for the new mother. The student should be urged to check with her health care provider for other exercises.

We have found that there are three main factors that motivate the pregnant adolescent to exercise. The first is her concern for her own well-being and ability to maintain control during her labor and delivery experience. The second is an almost universal concern over physical appearance. Finally, a young woman may be motivated to learn relaxation techniques to cope with stress and tension of everyday living.

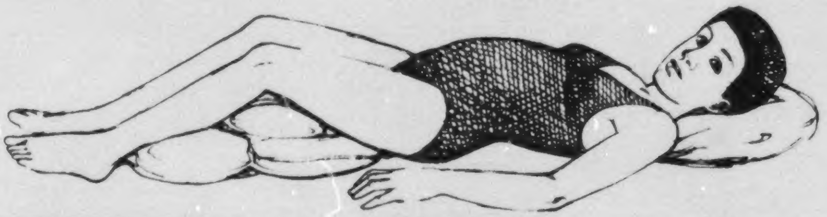
It has been our experience that when properly motivated, pregnant teenagers are responsive to a program of regular exercise. Initially they may experience some feelings of reluctance or awkwardness. For this reason it is essential that the teacher contribute to a relaxed, free atmosphere. If she is able to demonstrate the exercises in a relaxed, carefree manner, her students will be more likely to participate without embarrassment.

An exercise session is often a good time for an informal discussion of students' fears and concerns. In a classroom setting, exercises can be a good icebreaker, enabling students and teacher to laugh and talk together. Because of student embarrassment, a considerable amount of nervous laughter is to be expected. This laughter should not be interpreted as a lack of interest.

Girls differ in their ability to exercise. For this reason it's best to begin slowly with a gradual increase as the body adjusts. Stress the importance of regular exercise. If pain or serious discomfort occurs, the student should be encouraged to discontinue exercising and to consult her doctor.

I. Booklet Goals
  A. To describe exercises designed for perinatal muscle strengthening
  B. To describe exercises for relaxation and tension reduction
  C. To describe breathing techniques for use during labor and delivery
  D. To describe postpartum exercises designed to restore muscle tone

II. Important Concepts
  A. Muscle-strengthening exercises help maintain muscle tone during pregnancy



and prepare the body for the labor and delivery experience.

- B. Knowledge and use of relaxation and breathing techniques can favorably influence the progress of labor and delivery.
- C. Exercises done during the postpartum period will facilitate a faster recovery and strengthen muscles that were stretched during pregnancy.
- D. The adolescent may be motivated to do postpartum exercises by her concern for her personal appearance.
- E. A pattern of regular physical exercise has been shown to enhance physical and emotional stability throughout life.

III. Learning Objectives

The student will be able to do the following:

- A. Demonstrate the following prenatal conditioning exercises: tailor sitting, tailor stretch, Kegal, pelvic rock (two types), and squatting;
- B. Demonstrate relaxation techniques;
- C. Demonstrate abdominal, light shallow, and pant-blow breathing techniques for labor and delivery, and describe the period of labor in which each is most useful;
- D. Explain the purpose of postpartum exercises and describe which muscles may especially need the exercises to regain normal tone.

IV. Content Overview

	Text Page
A. Part I: Preparing for Childbirth	1-11

- 1. Section I. Exercises to Strengthen Muscles
  - a. Good posture
  - b. Tailor sitting
  - c. Tailor stretch
  - d. Kegal
  - e. Pelvic rock
  - f. Squatting
  - g. Ankle rotation
  - h. Calf stretching
- 2. Section II. Exercises to Relax the Body
  - a. Back position for relaxation
  - b. Lying on side
  - c. Breathing for relaxation
  - d. Muscle relaxing exercise
- 3. Section III. Breathing Exercises for Labor and Delivery
  - a. Complete or cleansing breath
  - b. Abdominal breathing
  - c. Light shallow breathing
  - d. Panting and blowing
  - e. Pushing

B. Part II. Postpartum Exercises 12-14

- 1. Section I. Exercises to Begin in the Hospital
  - a. Lying on abdomen
  - b. Walking
  - c. Head lift or "chin chest"
  - d. Leg lift
- 2. Section II. Exercises After You Are Stronger
  - a. Partial sit-ups or progressive chin chest
  - b. Leg raises

V. Suggested Learning Activities

- A. View film on perinatal exercise.
- B. Practice the exercises after they have been demonstrated.
- C. Invite a childbirth educator to speak on the importance of exercise and perhaps to demonstrate exercises.
- D. Research and report on which forms of exercise are healthy and appropriate during the childbearing experience and which are not.
- E. Discuss or answer in writing the questions in part VI.

VI. Questions for Discussion/Study Guide

- A. Which exercises can you do to make delivery easier?
- B. Which exercises can be done to help strengthen your lower back?
- C. How can learning to relax help you
  - 1. During pregnancy?
  - 2. During labor and delivery?
  - 3. After the baby is born?
- D. During what part of labor would you use the following types of breathing:
  - 1. Abdominal
  - 2. Light shallow
  - 3. Panting and blowing
- E. Which exercises can be begun while you are still in the hospital if you have had an uncomplicated labor and delivery?
- F. What is the main purpose of postpartum exercises? Which muscles generally need the most help to regain their normal muscle tone?
- G. Do you think you will exercise after delivery? Why or why not?

VII. Resource Materials

- A. Film: *Nine Months in Motion*
- B. Book: *Moving Through Pregnancy*, Bing

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"BREASTFEEDING: SOMETHING SPECIAL FOR MOTHER & BABY"

23 Pages

By Toni Berg

About the Booklet

The booklet, "Breastfeeding: Something Special for Mother and Baby," was written to provide the young mother with something she is not likely to find elsewhere: basic information about the oldest, simplest, and healthiest method of infant feeding. Most of the references available on breastfeeding are geared for the 20- to 30-year-old, educated, middle-class, white mother. You may find that these materials are not appropriate for your student population.

If you are using these materials, then you are in a position to assist the adolescent mother-to-be with her decision of which feeding method to use. It is very easy for the adolescent mother to choose bottle feeding. She is surrounded by advertisements for formula, by peer pressure, and sometimes by family pressure to bottle feed. She may not get adequate answers to her questions from her health care provider, or she may be actively discouraged from breastfeeding by medical personnel and hospital routines. Worst of all, she may have no factual information on which to base her decisions. Because of all these problems, the pregnant adolescent may look to you for the information and support that she needs to make an informed decision for herself and her baby.

The Committee on Nutrition of the American Academy of Pediatrics has endorsed breastfeeding as the preferred method of infant feeding for the first year of life and human milk as the preferred food. The Committee has also recently revised its stand on offering other foods to infants, now encouraging *all* parents to wait until the infant is five to six months old before starting any foods other than breast milk or formula.

Breastfeeding and the Adolescent Mother

Very little is known about the feeding practices of adolescent parents although it can probably be safely assumed that most bottle feed. There are many possible reasons.

(A) Lack of Information

Although there are several good references on breastfeeding available, these may not be available to the adolescent mother either because of reading level or expense. She may have nothing more to go on than old wives' tales and misinformation. One can easily see her point; she is struggling to be a "good mother," but the breast doesn't come with instructions on it as a can of formula does. One of the most important things we can do for the adolescent mother is to provide her with the information she needs about breastfeeding, starting early in pregnancy and continuing as needed. For many, the information regarding health benefits of breastfeeding may be enough since most mothers, both young and "older," want to provide the best for their babies.

(B) Pressure from peer groups, family, and baby's father

Very often the other people in a young mother's life are just as misinformed or uninformed about breastfeeding as she is. The adolescent mother is caught in conflicting emotions and situations. She is striving for independence from family, yet she has strong dependency needs at this particular time. Therefore, her family's opinions and wishes may carry a lot of weight. She may be involved in a relationship with the baby's father, who also has needs and may not understand that breastfeeding is one of the best things the young mother can do for herself, the baby, and him. Her peer group simply may not understand what is going on or why she wants to breastfeed when she could be going out with them. Education about breastfeeding should be provided to all the significant others in the adolescent mother's life to increase support for breastfeeding and to decrease the discouragements which many young women encounter.

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(C) Insecurity in the role of mothering

Many new mothers are very insecure in the mothering role. Insecurity may be especially intense in the adolescent mother. Bottle feeding may be very comforting to her because she can *see* how much milk the baby is taking. Because she is unable to see how much milk the baby is taking and because she has little control over the feeding, breastfeeding may increase her insecurity. If the baby doesn't seem hungry or has difficulty taking the nipple, the young mother may assume that the baby is rejecting *her*, not that the baby may be sleepy, etc. If she then offers a bottle and the baby gulps down two ounces, she will be devastated and think that her milk isn't any good. Education in breastfeeding must include all of the possible elements of early infant behavior, plus consideration of the hospital routines which may interfere with breastfeeding. When the mother *does* breastfeed for more than two weeks, the experience tends to enhance her feeling of ability in mothering.

(D) Body image

Depending upon the age and maturity level of the mother, there may be unresolved issues in body image and feelings about the development of the adolescent mother's body. If she is not ready to touch her body comfortably, in particular her breasts, she may not be able to breastfeed without embarrassment. If the young mother has been raised with the idea that touching herself is forbidden, the decision to breastfeed will be difficult for her to make. The adolescent mother needs the opportunity to voice her concerns and hopefully to resolve them.

(E) The need to show outwardly her independence

To the young mother, being able to *buy* things for her baby is often her way to show the world that she is capable of taking care of herself and the baby. In many cases the ability to buy formula is the desired activity while the decision to breastfeed may be an admission of poverty. The young mother may need help with the reality of childrearing in an age of inflation. Besides the cute little things that would be nice to buy, there are so many necessities that must be bought such as clothing and a place to sleep. Milk is one necessity that need not be an expense. If the baby is breastfed, more money is left for other necessities as well as for the nice but unnecessary things.

(F) Fear of being "tied down"

What the young mother may not realize is that the very fact she has a baby may be the factor that ties her down, not the method of feeding. She needs to be helped to see that schedules can be worked out so that the baby can be cared for and fed without the mother's sacrificing all things.

(G) Lack of encouragement from professionals

Perhaps this lack of encouragement is one of the most distressing factors in the adolescent mother's failure to breastfeed. The adolescent mother does not usually have the economic power, stamina, or knowledge to use the medical and educational system to her own advantage. She may be easily intimidated and discouraged. She may not know that she has certain rights, including the right to ask questions. When she encounters a professional who is insensitive to her needs and desires, she may give up rather than fight for what she feels is best. It is helpful when the helping people with whom the adolescent mother has contact are informed and ready to assist in any way possible.

Assisting the Adolescent Mother to Breastfeed

There are several factors that are important in assisting a mother with breastfeeding. First, she needs basic information about why it is worth the effort for reasons of health, economy, and convenience. Second, she needs instruction in the mechanisms of and preparation for breastfeeding in language that is easily understood and culturally acceptable to her. Third, she needs encouragement and continuing support in her decision to breastfeed.

The young mother needs a good understanding of these important factors: the "let-down reflex," supply and demand, and the psychophysiological basis of breastfeeding. If she understands that the more often the baby is allowed to nurse on demand, the more milk she will have, then she may not panic when the baby seems to want to eat all the time. She will know that the baby is experiencing a period of rapid growth and that her milk supply will soon catch up. The mother also needs a good understanding of the things that interfere with an adequate milk supply, in particular the offering of formula or other supplemental foods. The frequent use of bottles, including water, is discouraged because the bottle and artificial nipple may interfere with the sucking reflex, is confusing to the baby, and decreases the stimulation of milk production.

The mother may worry about weight gain in her infant, especially since she can't see the amount of milk being consumed. She may lack confidence in her body's ability to provide an adequate milk supply for the baby. This uncertainty usually passes after two to three months if breastfeeding is allowed to continue that long. However, she needs *constant* encouragement, perhaps backed by periodic weight checks to reassure her. Try to discourage the young mother from comparing her infant to any other, especially a bottle fed infant, since all babies gain at their own rate and since breastfed babies tend not to gain as quickly as bottle fed babies.

It is usually helpful for the young mother to have someone to call when crises occur or when questions arise. If you do not feel qualified to serve as a lactation counselor, then provide the young mother with the number of someone else to call. You might like to consult with a group, such as La Leche League, in your area. If you believe that a young mother may be having difficulty, it may be advantageous for you or the lactation counselor to initiate the contact. If your program has the resources for home visiting during the first two weeks after delivery, the home visitor can offer assistance. The first two weeks is often the time when women decide to discontinue breastfeeding.

Token Breastfeeding

There are cases in which mothers are really not interested in breastfeeding but are coerced into making that decision. These mothers may not be secure enough to elect to bottle feed against pressure. Often in these cases breastfeeding does not work, and there are a multitude of excuses for stopping.

It is very important that each adolescent mother be allowed to make her own decision and that her decision be supported as much as possible. It is preferable for a mother to face her deep feelings and decide to bottle feed rather than to pretend to breastfeed and to go through the physical discomfort and guilt of failure. Make yourself available to help the young mother with this decision; then stand behind her in whatever decision she makes even if you would not have made the same decision. Only she knows her own feelings and life situation.

I. Booklet Goals

A. To provide the adolescent mother with the information she needs to make an informed decision regarding feeding method

B. To provide the adolescent mother with guidance in the preparation for breastfeeding

C. To provide anticipatory guidance in dealing with common problems associated with breastfeeding

II. Important Concepts

A. Breastfeeding is a natural conclusion to the pregnancy cycle.

B. Human milk is specifically designed to meet the needs of the human baby.

C. Breastfeeding is beneficial to both mother and infant.

III. Learning Objectives

The student will be able to do the following:

A. List four health benefits of breastfeeding to the mother;

B. List five health benefits of breastfeeding to the infant;

C. List and explain three convenience advantages of breastfeeding;

D. Describe the care of the breasts for *any* pregnant woman;

E. List and demonstrate the preparation techniques needed to get ready for breastfeeding;

F. Describe the "let-down reflex" and explain its importance to successful breastfeeding;

G. List the steps in preventing and treating engorgement for the breastfeeding mother;

H. List the steps in treating engorgement for the non-breastfeeding mother;

I. List the steps for preventing and treating sore nipples;

J. List the steps and times in starting solid foods for the breastfed baby and the bottle-fed baby;

K. Describe the weaning process.

IV. Content Overview

Text Page

A. Reasons for breastfeeding 1-3
   1. Benefits to mother
   2. Benefits to baby
   3. Advantages of breastfeeding
B. Breast function 4-5
   1. Parts of breasts
   2. Colostrum
   3. Supply and demand system
   4. "Let-down reflex"
C. Preparation techniques 6-8
   1. Nipple rolling
   2. Breast massage
   3. Manual expression of colostrum
D. Care of the breasts 9
   1. Any pregnant woman
   2. Woman planning to breastfeed
E. Personal care 9
   1. Diet
   2. Fluids
   3. Rest
F. Getting started.................... 10, 11
   1. Nursing as soon as possible after delivery
   2. Handwashing
   3. Positioning

        4. Rooting reflex
        5. Length of nursing time the first day
        6. Breaking suction
        7. Burping
    G. Problems.......................... 11-14
        1. Engorgement
            a. Prevention
            b. Treatment for breastfeeding mothers
            c. Treatment for non-breastfeeding mothers
        2. Sore nipples
            a. Prevention
            b. Treatment
    H. Breastfeeding the older baby....... 14-19
        1. Feeding schedules
        2. Giving bottles
        3. Growth spurts
        4. Giving solid foods
        5. Weaning
    I. Questions and answers............ 19-22

V. Suggested Learning Activities
    A. View films on breastfeeding.
    B. Discuss benefits, advantages, and problems of breastfeeding.
    C. Demonstrate preparation techniques using flip chart or "Betsy Breast."
    D. Have a young mother(s) discuss her experience with breastfeeding
        1. After normal birth,
        2. After C-section,
        3. With premature baby.
    E. Discuss or answer in writing the questions in part VI.

VI. Questions for Discussion/Study Guide
    A. Name three health benefits of breastfeeding to the *mother.*
    B. Name five health benefits of breastfeeding to the *baby.*
    C. Compare the advantages of breastfeeding and bottle feeding.

Advantages of Breastfeeding	Advantages of Bottle Feeding

    D. What should any pregnant woman do to care for her breasts during pregnancy?
    E. Name at least three preparation exercises that should be practiced by the woman who plans to breastfeed.
    List three reasons why preparation is important.
    F. What is the function of each of these parts of the breast:
        1. Milk glands (alveoli)?
        2. Milk ducts?
        3. Collecting sinuses?
    G. What is engorgement? List the things that a woman can do to prevent engorgement.
    H. List the things a woman can do to treat engorgement.
    I. List the things that should be done to prevent sore nipples.
    J. List the things that can be done to *treat* sore nipples.
    K. List four stories about breastfeeding that are *not* true.
    L. Some women should not breastfeed. Name three times when this statement is true.

VII. Resource Materials
    A. Films:
        1. *Breastfeeding*
        2. *Breastfeeding: A Special Closeness*
        3. *The Breastfeeding Experience*
        4. *Breastfeeding: The Natural Way*
        5. *Breastfeeding: Prenatal and Postnatal Preparation*
    B. Flip Chart: "Breastfeeding Your Baby," Mead Johnson Laboratories
    C. Pamphlet: *Have You Considered Breastfeeding Your Baby,* Haire
    D. Books:
        1. *Abreast of the Times,* Applebaum
        2. *The Complete Book of Breastfeeding,* Eiger and Olds
        3. *Human Milk in the Modern World,* Jelliffe and Jelliffe
        4. *Nursing Your Baby,* Pryor
        5. *Please Breastfeed Your Baby,* Girard
        6. *Preparation for Breast Feeding,* Ewy and Ewy
        7. *Successful Breastfeeding,* Phillips
        8. *The Tender Gift: Breastfeeding,* Raphael
        9. *The Womanly Art of Breastfeeding,* La Leche League
        10. *You Can Breastfeed Your Baby (Even in Special Situations),* Brewster
    E. Articles:
        1. "Breastfeeding and Care of the Breasts," Applebaum
        2. "Human Milk, Nutrition and World Resource Crisis," Jelliffe and Jelliffe
        3. "Nutritional Value of Human Milk," Baum
        4. "Nursing the Newborn," Berg
        5. "Psychological Differences Between Breast and Bottle Feeding," Newton
        6. "The Uniqueness of Human Milk," Jelliffe and Jelliffe

Part Seven

RESOURCE MATERIALS

RESOURCE MATERIALS

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1. Audio-Visual Resources

A. Films

1. Film Sources

American Education Films
132 Lasky Drive
Beverly Hills, California 90212

B.F.A. Educational Media
2211 Michigan Avenue
Santa Monica, California 90404

Carolina Population Center
113 Mallette Street
Chapel Hill, North Carolina 27514

Centre Films, Inc.
1103 N. El Centro Avenue
Hollywood, California 90038
Phone: (213) 466-5123

Centron Educational Films
1621 W. 9th Street
P.O. Box 687
Lawrence, Kansas 66044

Children's Home Society of California
Public Relations Department
3100 W. Adams Boulevard
Los Angeles, California 90018

Churchill Films
662 N. Robertson Boulevard
Los Angeles, California 90069
Phone: (213) 657-5110

Films, Incorporated (Main Office)
1144 Wilmette Avenue
Wilmette, Illinois 60091
phone: (800) 323-4222 (toll free)

Health Sciences Communication Center
Marketing Division
Room WA-6725
Case Western Reserve University
Cleveland, Ohio 44106
phone: (216) 368-3776

Indiana University Audio-Visual Center
NET Film Service
Bloomington, Indiana 47401
phone: (812) 337-8087

Johnson and Johnson
Consumer and Professional Services Dept.
220 Centennial Avenue
Piscataway, New Jersey 08854

Lawren Productions, Inc.
P.O. Box 666
Mendocino, California 95460
phone: (707) 937-0536

March of Dimes Birth Defects Foundation
Box 2000
White Plains, New York 10602

McGraw-Hill Films
1221 Avenue of the Americas
New York, New York 10020

Mead Johnson Laboratories
Manager, Meetings and Exhibits
2404 Pennsylvania Street
Evansville, Indiana 47721

Media for Childbirth Education
P.O. Box 2092
Castro Valley, California 94546

Motion, Inc.
4437 Klingle Street N.W.
Washington, D.C. 20016
phone: (202) 363-9450

New York University Film Library
26 Washington Place
New York, New York 10003
phone: (213) 598-2250, 2251, 2252

Parenting Pictures
R.D. #1, Box 355-B
Columbia, New Jersey 07832
phone: (201) 475-3132

Perennial Education, Inc.
477 Roger Williams
P.O. Box 855, Ravinia
Highland Park, Illinois 60035
phone: (312) 433-1610

Phoenix Films
470 Park Avenue South
New York, New York 10016

Polymorph Films
331 Newbury Street
Boston, Massachusetts 02115
phone: (617) 262-5960

Proctor and Gamble
Pampers Professional Services Division
P.O. Box 171
Cincinnati, Ohio 54201

Pyramid Films
P.O. Box 1804
Santa Monica, California 90406
phone: (216) 541-1554

Rocom International
Hoffman La Roche and Co.
Montclair, New Jersey 07042

Ross Labs
Columbus, Ohio 43216

Texture Films
1600 Broadway
New York, New York 10019
phone: (212) 586-6960

University of California
Extension Media Center
2223 Fulton Street
Berkeley, California 94720

West Glen Films
565 Fifth Avenue
New York, New York 10017

Wyeth International Ltd.
P.O. Box 8616
Philadelphia, Pennsylvania 19101

2. Film List

Abby's First Two Years, A Backward Look, 30 min., B & W, sound, rental $12, NYU Film Library. Shows the development of a normal child from 2 months through 24 months.

About Conception and Contraception, 11 min., color, no sound, 1975, rental $14, Perennial Education. Very clear, animated drawings illustrating birth control devices and how they prevent conception. This film is not narrated, so the presenter can explain the content in terminology appropriate to the audience. Also available in Spanish.

About Sex, 24 min., color, sound, 1972, rental $18, University of California. An integrated group of teenagers sit around with a group leader discussing their feelings about many aspects of sexuality. Sex myths are discredited in a candid way by the group leader. There are sequences about sexual fantasies, body growth, homosexuality, birth control, masturbation, and abortion.

Accident Prevention, 10 min., color, sound, Rocom (Roche Labs). Discusses many types of accidents that can be prevented.

Adapting to Parenthood, 20 min., color, sound, 1975, rental $30, Polymorph Films. Parents of newborns describe their experiences and discuss that although prepared for childbirth, they weren't adequately prepared for the demands of parenthood. Couple oriented.

Alcohol: Crisis for the Unborn, 16 min., color, sound, free loan, March of Dimes. The film graphically depicts the fetal alcohol syndrome, showing the tragic outcome of drinking during pregnancy.

The Amazing Newborn, 25 min., color, sound, (recent), rental $40, Health Sciences Communication Center, or free loan preview from Ross Laboratories; contact local Ross representative. A film portraying the behavioral development of normal newborns already present at birth, and its importance in the beginning of communication between parents and their newborn infants. Produced in consultation with Marshall Klaus, M.D. Very good!

Are You Ready for the Post Partum Experience?, 17 min., color, sound, 1975, rental $25, Parenting Pictures. Film shows couple learning to care for baby, feelings which may accompany the adjustments to new situation as parents. Some discussion/presentation of husband-wife relationships, depression, anxiety and fears, sleep deprivation, breast and bottle feeding, maternal physical recovery, pride and satisfaction of new parenthood. Very good!

Baths and Babies, 17½ min., color, sound, 1965, free, Johnson and Johnson Baby Products Co. A film designed to help new mothers learn how to bathe their newborns.

Bernita's Film, 28 min., color, sound, 1976, rental $35, Centre Films. Bernita is a black, unmarried teenager who is taken through her pregnancy, including prenatal visits to the doctor and Lamaze classes. Her labor is shown, but not the actual delivery. The problems of early parenting are depicted as she feeds her baby and does laundry. It is a very realistic film about single parenthood.

Biography of the Unborn, 17 min., B & W, sound, 1956, rental $10, NYU Film Library, or $10.25, Perennial Ed. Designed to show fetal development by X-ray and live photography and the effects of outside influences on the fetus. Old, but interesting.

Birds, Bees, and the Stork, 8 min., color, sound, McGraw-Hill. A humorous cartoon dealing with embarrassment about discussing sex. It is an excellent ice-breaker for classroom use or parent meetings. Voice is by Peter Sellers.

Birth Control: The Choices, 25 min., color, sound, 1976, rental $25, Churchill Films. Replacement film for *To Plan Your Family*. It explores all the methods, their uses, limitations, and side effects.

Birth Day, Through the Eyes of the Mother, 30 min., color, sound, 1970, rental $30, Lawren Productions, Inc. Filmed for the Crittendon Association. Shows labor and the birth of her baby from the mother's point of view. Good for use with single mothers as there is no husband or partner present.

Birth of a Family, 24 min., color, sound, 1975, rental $30, Perennial Education. Designed for couples or single women to demonstrate preparation for childbirth. We see one couple attending a class on childbirth preparation. Scenes of class instruction are intermingled with scenes of the actual birth, including the episiotomy. The film demonstrates the relationship between careful preparation and actual delivery.

The Bonding Birth Experience, 22 min., color, sound, 1977, rental $32, Parenting Pictures. The film follows an expectant family from early labor at home, through their hospital labor and birth, and initial stages of family attachment, postpartum in the hospital, breastfeeding, to home adjustments. The emphasis is on the emotions of labor and birth rather than the instruction of specific techniques. Very good!

Born Hooked, 13½ min., color, sound, free loan, March of Dimes. Shows the infant undergoing the stress of withdrawal from heroin and stresses the need for prenatal care for mothers addicted to heroin or methadone.

Boy to Man, 15 min., color, sound, 1976 (rev), rental $15, NYU Film Library. This film deals with the physical and emotional changes of puberty (sweat, acne, hair, attitudes towards girls, etc.). Also briefly covers female reproductive anatomy to demonstrate conception.

Breastfeeding, 20 min., color, sound, 1975, Wyeth International, available for purchase only, not available for rental. Beautifully done presentation of the reasons for breastfeeding, as well as some of the possible difficulties. Good film for presentation to expectant parents who have not decided the feeding issue, and good reinforcement for those who have decided to breastfeed. Winner of the Bronze Medal Award at the British Film Festival, 1975.

Breastfeeding: A Special Closeness, 23 min., color, sound, 1977, rental $40, Motion, Inc. An introduction to infant care and nurturing, featuring different ethnic and economic groups and exploring the issues surrounding breastfeeding. Deals with questions and concerns of expectant parents. In their own words, mothers and fathers speak of their individual solutions to living and working with a nursing infant.

The Breastfeeding Experience, 20 min., color, sound, 1978, rental $35, Parenting Pictures. Mothers from multiple ethnic and cultural groups discuss their breastfeeding experiences, including common difficulties and satisfactions. Excellent!

Breastfeeding: The Natural Way, 15 min., color, sound, free rental from Ross detail man in your area, Ross Laboratories. Describes the function of the breast, how breastfeeding works, and the basics of getting started. A good film.

Breastfeeding: Prenatal and Postpartal Preparation, 26 min., color, sound, 1975, rental $35, Health Sciences Communication Center. Film shows prenatal instruction of routine breast exercises and postpartum instruction of useful techniques for breastfeeding the newborn.

The Cesarean Birth Experience, 25 min., color, sound, 1976, rental $35, Parenting Pictures. Film shows scenes of two separate Cesarean births using different anesthesia and techniques; discusses reasons for Cesarean delivery, care of mother and infant, parents' feelings, breastfeeding, and includes discussion of many mothers' different Cesarean birth experiences. Very good!

Childhood: The Enchanted Years, 52 min., color, sound, 1970, rental $25, Films, Inc. Film illustrates child development from birth to school age, marking some important milestones in this process. It is a partial analysis of how children grow up to be competent adults. It includes some of the basic research works of such researchers as Burton White. Produced for television and is from the child's eye view.

A Child Is Born, 22 min., color, sound, 1971, rental $22, BFA Educational Media. This film is a good overview of pregnancy and delivery. It follows a Swedish couple through the experience, plus some still photos by Nilsson.

The Choice, 5½ min., March of Dimes. A short film discussing choices one can make regarding smoking, the use of drugs, etc., as they relate to pregnancy. A good discussion starter.

Contraception: Yesterday and Today, color, sound, 1978, Eaton-Merz Laboratories, Inc., Norwich NY 13815. This film discusses the history of contraception as well as today's most commonly used methods. In addition to how the methods work, the potential side effects, complications, and effectiveness rates are discussed. It is an excellent film for educating the consumer about birth control choices. Additional instruction on how to use the methods should follow.

Eat, Drink and Be Wary, 20 min., color, sound, 1975, Churchill. This film deals with nutrition in our American society: processed foods, additives, artificial colorings and flavorings, and high sugar content. It also demonstrates the media's influence on nutrition through advertising.

Emotional Aspects of Pregnancy, 20 min., color, sound, 1977, rental $30, Perennial Ed., Inc. The film deals with the emotional changes of pregnancy, highlighting the intensity of emotional reactions, the new dimensions in relationships, the vivid dream life of the woman, and the fluctuation of sexual desire. Excellent!

A Family Talks About Sex, 28½ min., color, sound, 1977, rental $32.50, Perennial Ed., Inc. A series of short vignettes illustrate how families can and should communicate about sex. Deals with young children up through teenage years. Excellent!

First Two Weeks of Life, 17 min., color, sound, 1973, free from Proctor & Gamble Co. The film is about childbirth and the first two weeks of the newborn's life. It was designed to reduce the fears that young couples experience when faced with the responsibility of a first child.

***A Gift, An Obligation*, 27 min., color, sound, 1978, free loan, West Glen Films. This film recreates the time a few years ago when diseases such as polio, measles, diphtheria, etc., were a common threat to childhood health. It emphasizes the importance of vaccinations to prevent these diseases.**

Girl to Woman, 16 min., color, sound, 1976 (rev), rental $15, NYU Film Library. Shows the growth and development during the turbulent change from girl to woman. Also describes the male reproductive system.

Goodbye Lynn, 21 min., color, sound, 1972, rental $31, Centron Educational Films. The film recounts Lynn's own story of her feelings about being a pregnant, unwed teen. Could be used as a community awareness tool of the problems faced by a pregnant adolescent or with pregnant teens to help them realize that others share their feelings. The short dress styles of 1972 are obvious.

Great Expectations, 22 min., color, sound, recent, rental $20, Society for Nutrition Education, or free from local chapters of the March of Dimes. Shopping, preparing, and eating a wide variety of wholesome food is shown. Women and their families come from a variety of ethnic backgrounds. Weight gain and nutrition in pregnancy, importance and reasons for breastfeeding are explained and discussed.

Growing Up Together, 55 min., color, sound (2 reels), or 28 min. (combined version), Children's Home Society. Four young mothers discuss their experiences, thoughts and feelings about parenthood. The characters in the film are real and the action takes place in their own homes. The film is designed to portray the realities of teenage motherhood as well as the effects on children and other family members. This film can be used to stimulate discussion of parenting practices, needs of mother and child, and possible solutions to common problems. For discussion purposes, it is recommended that the cases be discussed separately.

Have A Healthy Baby: Labor and Delivery, 29 min., color, sound, 1978, Churchill Films. An excellent film showing the actual labor and deliveries of two couples. The labor process is shown through extraordinarily clear and detailed animation.

Have A Healthy Baby:Pregnancy, 22 min., color, sound, 1978, rental $9.25, Indiana University Audio Visual Center, or Churchill Films. An updated version of *Have A Healthy Baby* that shows fetal development through animation paralleled with mothers talking about their pregnancies and health care habits. Excellent!

Hope Is Not a Method, 17 min., color, sound, 1977, rental $25, Perennial Education. The film is designed for sexually active persons who wish to contracept. All methods are discussed in a sensitive, scientific manner.

How About You?, 25 min., B & W, sound, rental $35, Texture Films. Provides specific factual information about the way the female body functions and the major methods of birth control. In a rap session with young men and women, sexuality, sex roles, and birth are discussed.

How Babies Learn, 35 min., color, sound, 1965, rental $18, NYU Film Library. Describes the important milestones in development during the first year. The value of the mother-child relationship is emphasized.

Human Growth III, 20 min., color, sound, 1976, rental $28, Perennial Ed., Inc. This film covers anatomy, physiology, menstruation, conception, and birth through illustration. Young adolescents talk about growing up emotionally and physically. Some young married couples discuss having or not having children.

Human Reproduction, 21 min., color, sound, 1965, rental $13, NYU Film Library, or $20 from McGraw-Hill. This film shows by models and animation the human male and female reproductive systems. Menstruation, development of the baby, and birth are shown by animation. Although an old film, it talks about menstruation in a clear, understandable manner.

I'm 17, Pregnant, and Don't Know What To Do, 28 min., color, sound, 1970, Children's Home Society of California. The story of a young pregnant girl who decides to keep her baby. The film discusses the problems she has and finally, the release of her child at 14 months for adoption.

Linda's Film on Menstruation, 18 min., color, sound, 1974, rental $30, Phoenix Films. This film is about a teenager who has her period for the first time. It is done in a clever informative manner discussing facts, myths, and attitudes regarding menstruation.

Look What's Going Around, 16 min., color, sound, Churchill. Film shows the symptoms, transmission, cure and prevention of syphilis and gonorrhea. It deals with the feelings of teenagers about going to a VD clinic.

Lynn and Smitty, 16 min., color, sound, 1972, rental $5 (purchase $80), Dr. Norman Kendall, Temple University Hospital, Philadelphia, PA 19140. A film narrated by a black couple about their own birth experience. Flashbacks are used to show prenatal care. Warm, sensitive delivery with no perineal views.

The Miracle of Life, 15 min., color, sound, 1977, rental $30, Pyramid. Adapted from the documentary "The Beginning of Life." Film shows photographs of the reproduction system, including ovulation, fertilization, and early fetal development.

Newborn, 29 min., color, sound, 1972, free loan from Johnson & Johnson, or West Glen Films. This film focuses on the early adjustments to parenthood. It is a non-commercial presentation directing itself to both bottle and breastfeeding.

Nine Months In Motion, 19 min., color, sound, 1977, rental $28.50, Perennial Ed. Emphasis of this film is on the importance of physical fitness during pregnancy. The prenatal exercises are demonstrated.

Nutrition: The Inner Environment, 15 min., color, sound, American Education Film. This film emphasizes that what we eat influences how we look, act, and feel, and how we think. The process of digestion is presented in an animated form.

Old Enough To Know, 20 min., color, sound, 1975, rental $22.50, Perennial Education. A film designed to deal with attitudes as parents share their concerns and embarassments in discussing sex education. Small children ask candid questions and are answered in a warm, sensitive manner.

Parent To Child About Sex, 31 min., color, sound, 1968, rental $28, Perennial Education; also, $18.50 from NYU Film Library. This film deals with parents teaching their children about sex. It presents positive and negative ways of dealing with sexuality issues (masturbation, menstruation, and dating).

Parenting Concerns: The First Two Years, 11 min., color, sound, 1977, rental $30, Perennial Education. Film examines common childrearing situations and proposes possible solutions.

Prenatal Care, 24 min., color, sound, Pyramid Films, 1977. Film covers four aspects of prenatal care: doctor's care, precautions, normal changes, and preparation for birth. One of the most comprehensive films on prenatal care we have seen!

Super Goop, 13 min., color, sound, 1975, rental $18, Churchill Films. An animated story in which Rodney and Charlie, actor and ad man, concoct a TV commercial for a ghastly cereal, revealing how commercials con kids into wanting the stuff.

Teenage Father, 29 min., color, sound, 1977, Children's Home Society. This film is a realistic portrayal of an unmarried teenage couple and the decisions they have to make. There are scenes showing the interaction of the boy with his friends, family, social worker, and girlfriend. There is also interaction between the girl and her family. Excellent for training and to be used to elicit the feelings of young pregnant woman toward the fathers of their babies.

Teen Sexuality: What's Right For You, 30 min., color, sound, 1977, Perennial Education. Gives information about sexual relationships, birth control, etc., and discusses morality and values concerning teenage sex. It gives the teen the chance to decide for herself how she feels about the subject.

Then One Year, 19 min., color, sound, 1972, Churchill Films. A popular film describing the primary and secondary changes in adolescents. This film is a combination of "Boy To Man" and "Girl To Woman."

To Plan Your Family, 14 min., color, sound, 1971, rental $12.50, NYU Film Library, or Churchill Films. This film shows the birth control methods and discusses the reasons for planning families through interviewing several different women. The 1976 update of this film is entitled, *Birth Control: The Choices*, also available from Churchill Films.

Tomorrow's Children, 17 min., color, sound, early 70's, rental $22, Perennial Education. The problem of population growth is explored in this well-photographed film. The viewer sees the shift in relationship between man and nature as it changes from give and take to control. It presents a plea for future generations that will inherit the earth.

Under One Roof, 25 min., color, sound, Carolina Population Center. Discusses the importance of family planning by showing several different types of families. Mothers discuss their daily activities and feelings about having large families.

Venereal Diseases, 17 min., color, sound, John Wiley & Son. Discusses the symptoms, diagnosis, treatment, and prevention of VD in an explicit manner.

When Life Begins, 14 min., color, sound, 1972, rental $15, McGraw-Hill. Through microcinematography, the film records a very realistic sequence of events in the growth and development of the human fetus from ovulation to birth. This film would best be used after a discussion on fetal development, as the vocabulary is on a high level.

Woman-Child, 18 min., color, sound, 1978, free from March of Dimes. This film deals realistically and poignantly with the problems faced by pregnant adolescents. It would be a good discussion starter for pregnant teens and community groups.

Young, Single, and Pregnant, 18 min., color, sound, rental $26.50, Perennial Education, mid 70's. Story of four young women and the decisions they made regarding their unplanned pregnancies — adoption, abortion, marriage, and single motherhood. It would be a good discussion opener for discussion of options.

Your Pelvic and Breast Exam, 12 min., color, sound, 1977, rental $17.50, Perennial Education. This film shows several different women expressing their feelings about getting a pelvic exam. A pelvic and breast exam are given by a clinician as she explains what she is doing.

B. Filmstrips/Cassettes

Infant Care and Development Series, McGraw-Hill Films.

Child Care and Development, Set 1
"Children's Play"
"Food Needs of Children"
"Caring for Children: An Important Job"
"Clothing Needs of Children"

Child Care and Development, Set 2
"Anxieties of Children"
"Discipline and Punishment"
"Influences of Children"
"Intellectual Development of Children"

Inside My Mom, 8 min., Filmstrip or slides, color, 1975, free from local chapter or national March of Dimes. This popular filmstrip focuses on the importance of good nutrition during pregnancy, combining cartoons and live action. The narrator, a talking fetus, offers sound nutritional advice and makes it clear that she shares everything with her mother. (Also available in Spanish.)

Life Before Birth, Parts I and II, two color filmstrips and 30 min. cassette, $50, Time Life Multimedia, 100 Eisenhower Drive, Paramus, NJ 07652, or two color filmstrips with captions, $10 per strip, Primary Communications, 135 East Pennsylvania Ave., Southern Pines, NC 28387. Fetal development depicted by photographs by Nilsson from ovulation to birth.

Parents' Magazine Films, Inc., Dept. "F,"
52 Vanderbilt Ave, New York, NY 10017,
preview for 30 days without obligation.

Building a Future, a series of five filmstrips and cassettes, 1977. The series was made for school-age parents and deals with parenthood as it relates to its challenges and rewards, independence, relationships, etc.

Child Development and Child Health, "Health and Safety," a series of five filmstrips and cassettes, 1975. This series deals in depth with safety and first aid for children as well as home care for the sick child.

Child Development and Child Health, "Love and Identity," a series of five filmstrips and cassettes, 1975. A child development series on the growing child as it relates to love, food, the need for attention, independence, and the Oedipal Phase.

Dealing with Practical Problems of Parenthood, a series of four filmstrips and cassettes, 1977. This series is aimed at the younger parent dealing with prenatal health needs, finding day care, emotional support, and keeping the baby healthy.

Tomorrow Happens Today, color, mid 70's, free from local chapter, March of Dimes. This film strip very graphically shows the harm to the unborn baby from German measles, syphilis, thalidomide, etc. We suggest you preview it before showing and follow with a reassuring discussion.

C. Slides/Cassettes

Birth and Bonding, slides/cassette, color, Media for Childbirth Education, 1979, P.O. Box 2092, Castro Valley, CA 94546. The slides depict the importance of early infant contact and show what to do to enhance the first moments of life. An extensive manual accompanies the program.

Birth Atlas Slide Series, 22 slides, 24-page booklet, $10.50, Maternity Center Association. This series was adapted from the "Birth Atlas" and includes illustrations of breech labors and male and female reproductive organs.

Chance or Choice — Nutrition Option for Pregnant Teens, video-tape cassette, 16 min., color, rental $25, Education Media. Six teenagers speak out on their own approaches to nutrition during pregnancy. Designed as a catalyst for group discussion, this tape emphasizes the connection between nutrition and fetal development.

I'm Not Bad, Just Pregnant, 80 slides, 30 min., available for loan in New Mexico only from New Futures School. A student-made production dealing with the feelings and decisions that surround a pregnant adolescent, her boyfriend, and their families.

Lullaby from the Womb, 1974, record or cassette, ICEA Bookcenter, P.O. Box 70258, Seattle, WA 98107, $6.98. Uterine sounds which can be used for classroom instruction or to soothe the newborn.

The Nurturing Father, 80 color slides/cassettes, Media for Childbirth Education, 1979, P.O. Box 2092, Castro Valley, CA 94546. This series is designed to prepare expectant fathers for a nurturing role with their children.

D. Charts, Games, Models

"Basic Four Food Charts, Food Models, and Comparison Cards," available from the National Dairy Council, Rosemont, IL 60018.

"Breastfeeding Your Baby," Mead-Johnson, Evansville, IN 47708.

"Cervical Dilatation," Ross Laboratories, Columbus, OH 43216. Chart is three-dimensional and shows the dilatation and effacement of the cervix in various stages of labor. Free.

Charts from the Maternity Center Association, 48 East 92nd St., New York, NY 10028.

"Birth Atlas," flipchart, 14" x 20", 19 pages, $15. A classic series of charts showing in detail fertilization, fetal development, labor, and birth.

"Female Pelvis," chart, 17" x 28", $1.00. This is a normal female pelvis showing all structural and anatomical landmarks.

"Newborn Baby," chart, 14" x 20", 80 cents.

"Organs of Human Reproduction," chart 17" x 28", $1.00.

"Relation of Growing Uterus to Other Organs," 5 charts, 17" x 28", 5 instruction leaflets, $4.00.

"Shape and Structure of Breasts," chart, 17" x 22", $1.00. The lactating and non-lactating breasts, full view and cross section.

"The Female Reproductive System: Illustrations for Patient Counseling," G.D. Searle & Co., Medical Communications Dept., Box 5110, Chicago, IL 60680.

"Male and Female Complete Body Charts," Spenco Medical Corporation, P.O. Box 8113, Waco, TX 76710. Two lifesize charts. The middle section of each can be interchanged with a different section that hooks onto the chart. These sections include:

Male — 1) Reproductive System
2) Urinary System
3) Erection of the Penis
4) Ejaculation

Female — 1) Reproductive Organs
2) Menstruation
3) Fertilization
4) Early Pregnancy
5) Second Trimester Pregnancy

"Pelvic Model and Birth Control Demonstration Kit," Ortho Pharmaceutical Co., Raritan, NJ 08869. Useful tools for teaching family planning.

"The Pregnancy Game," 5730 River Oak Way, Carmichael, CA 95608, $7.40. This game is a new learning and communication experience for expectant parents. The game is designed to help students discover and share their feelings about pregnancy and parenthood and to develop realistic plans and expectations for the first year of their baby's life. Factual information on pregnancy, birth, and infant development is presented along with material to help students deal with emotional and practical issues. The game consists of a playing board depicting the 40 weeks of pregnancy, question cards, and a resource book with a discussion of each question.

"V.D. Dial," Spenco Medical Corporation, P.O. Box 8113 Waco, TX 76710 (catalogue available). A small cardboard chart giving common names, symptoms, diagnosis, and treatment of several venereal diseases.

"Wheel of Fortune," YWCA of Los Angeles, 1970. This game is designed as part of a vocational readiness program to stimulate thought about career and marriage choices.

II. Printed Resources

A. Sources of Inexpensive and/or Free Materials

Gerber Products Company
Fremont, Michigan 49412

Johnson and Johnson Baby Products Company
The Consumer and Professional Services Department,
220 Centennial Avenue
Piscataway, New Jersey 08854

March of Dimes Birth Defects Foundation,
Box 2000
White Plains, New York 10602

Mead Johnson Laboratories
Evansville, Indiana 47708

National Dairy Council
Rosemont, Illinois 60018

Ortho Pharmaceutical Corporation
Raritan, New Jersey 08869

Planned Parenthood — World Population
810 Seventh Avenue
New York, New York 10019

Proctor and Gamble
Education Division
Cincinnati, Ohio 45201

Ross Laboratories
Columbus, Ohio 43216

U.S. Government Offices:

Lulu Mae Nix, EdD, Director
Office of Adolescent Pregnancy
Programs
Humphrey Building, Room 725-H
200 Independence Avenue, S.W.
Washington, D.C. 20201

Superintendent of Documents
U.S. Government Printing Office
Washington, D.C. 20402

W. Stanley Kruger
Parent/Early Childhood and
Special Program Staff
Bureau of School Improvement
400 Maryland Avenue, S.W., Room 2083
Washington, D.C. 20202

Wyeth Laboratories
Philadelphia, Pennsylvania 19101

B. Pamphlets, Bulletins

American Association of
Obstetricians and Gynecologists
1 East Wacker
Chicago, Illinois 60601:

Adolescent Perinatal Health: A Guidebook for Services, 1979

Assessment of Maternal Nutrition, 1978

American Cancer Society
777 3rd Avenue
New York, New York 10017:

Pap Smear: What Is It?

When a Woman Smokes

Channing L. Bete Company
Greenfield, Massachusetts:

Your Child's Potential to Learn, 1977.

Budlong Press
5428 North Virginia Avenue
Chicago, Illinois 60625:

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Your New Baby and Your New Life, Neimark, 1977

Emory University
Box 26069
80 Butler Street, S.E.
Atlanta, Georgia 30303:

What's Happening Now?, 1978

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Fremont, Michigan 49412:

Baby Food Ingredients — What Do They Really Mean To Your Baby's Health? (professional), 1977

Expectant Mothers Guide, 1974

Foods for Baby and Mealtime Psychology, 1976

Infant Nutrition (professional), 1972

Other charts and pictures available at no charge.

ICEA P/D Center
Box 9316
Rochester, New York 14604:

Have You Considered Breast-Feeding Your Baby, 1972

Johnson and Johnson
220 Centennial Avenue
Piscataway, New Jersey 08854:

Baby Care Basics, 1977 (also available in Spanish)

Baby Chart, 1977 (17" x 21" developmental chart, also available in Spanish)

First Time Parents, 1976 (also available in Spanish)

Getting To Know Your Newborn, 1978

March of Dimes
Box 2000
White Plains
New York 10602:

"PEP" Materials (Preparenthood Education Program), $30 entire set:

Days of Change
Developmental Time-Line Chart
Food for Thought and Eating
Inside Your Body, Inside Your Head
Junk Food Blues
Month by Month Pregnancy Diet cards
Nutrition Education Cards
Wall Posters

Other March of Dimes pamphlets:

Be Good to Your Baby Before It's Born
Birth Defects: Tragedy and Hope
DATA: Drug, Alcohol, and Tobacco Abuse
Facts About Sickle Cell Anemia
Facts: 1979
Genetic Counseling
If You Drink, Your Unborn Baby Does, Too
My Child has Down's Syndrome
Nutrition and Pregnancy
Preventing Birth Defects Caused by Rubella
Venereal Disease Hurts You and the Unborn

Mead Johnson Laboratories
Evansville, Indiana 47708:

Jaundice and Your Baby, 1978
Names for Boys and Girls, 1976

National Dairy Council
Rosemont, Illinois 60018:

Food and You — Partners in Growth During Pregnancy, 1977
A Guide to Good Eating, 1976
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National Organization for Non-Parents:
80 Reistertown Road
Baltimore, Maryland 21208

Am I Parent Material?

Ortho Pharmaceutical Corporation
Raritan, New Jersey 08869:

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New York, New York 10010:

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Nearly Every Woman Gets It, 1979
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149 Grand Street
White Plains, New york 10601:

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Columbus, Ohio 43216:

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How Your Child Learns About Sex, 1978
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TEACHER'S MANUAL
for
TEENAGE PREGNANCY: A NEW BEGINNING

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Philosophy of Education for Effective Parenthood

We believe that the responsibility of parenthood begins at conception. Therefore, becoming an effective parent begins with the way the expectant mother cares for herself and her unborn child.

The ability to parent effectively is no accident. It is a learned process through the acquisition of knowledge of child development and child care skills. Even more important, it is learning to give a child love, acceptance, and help to learn.

Learning to be a parent begins when you are a child and is an on-going process throughout life. The way you feel about yourself (your self-concept) influences your ability to parent. The amount of love you have to give a child depends on how much you love and respect yourself. Your ability to give is no greater than what you have. Your ability to parent will also be affected by how well you cope with the other things happening in your life.

To become an effective parent, it helps to:

(1) have a positive feeling toward yourself

(2) believe you are capable of becoming the type of parent you want to be

(3) evaluate the way you were parented and realize you may parent the same way unless you consciously choose to do otherwise

(4) realistically understand the responsibilities of parenthood

(5) understand the physical, mental and social needs of the developing child

(6) formulate realistic expectations for yourself and your child

(7) learn ways of reducing tensions and methods of coping

We believe that acceptance and practice of family planning concepts may also affect your ability to parent. Planning for and spacing children may help a mother to avoid many stresses of parenthood and to give adequate attention to each child. However, we understand that family planning concepts are unacceptable to some people. We respect this point of view.

Linda Barr
Catherine Monserrat

Family Life Specialists
New Futures School
January, 1978

General Goals and Objectives
of
Teenage Pregnancy: A New Beginning

To provide information to school-age parents to help them to:

1) Achieve greater emotional and mental stability with emphasis on the development of a positive self-concept.

2) Understand and assume the responsibilities of parenthood.

3) Understand the anatomy and physiology of human reproduction as a basis for understanding conception, pregnancy, childbirth, and family planning.

4) Understand the process of fetal growth and development and the causes and prevention of birth defects.

5) Understand the physical and emotional aspects of prenatal, intrapartal, and postpartal care, with emphasis on the normal and natural rather than the abnormal and exceptional.

6) Develop self-awareness and understand the problem-solving process as a basis for sound decision-making.

7) Understand the characteristics and needs of the infant and develop confidence in the parenting role.

8) Increase awareness and understanding of family planning and birth control methods in relation to the individual, the family, and society as a whole.

Chapter One

"Teenagers Talk About Their Pregnancies"

I. Objectives

A. To present an overview of teenagers' reactions to their pregnancies.

B. To encourage personal exploration of thoughts and feelings related to pregnancy.

C. To help the young mother express and cope with her concerns about pregnancy.

II. Generalizations

A. The pregnant adolescent may confront unfamiliar feelings and circumstances.

B. The normal hormonal and psychological changes of pregnancy may cause emotional instability in the mother.

III. Student Objectives

The purpose of this chapter is to present an overview of teenage reactions to pregnancy and to help the student get in touch with her own feelings. For this reason, there are no stated behavioral objectives. However, the teacher should be alert to the possibility that the student may need assistance with a variety of concerns and be ready to offer support and/or appropriate referral.

IV. Content

A. Reactions to pregnancy
(NOTE: The teacher's acceptance and respect for a girl may be a major factor in how the young mother reacts to pregnancy and views herself.)

B. Moods
(NOTE: When working with pregnant adolescents, it is important to remember that mood swings are a reality. These will influence the student's interaction with the teacher, as well as her performance in the classroom.)

C. Body image
(NOTE: Teens are often quite sensitive about their appearance and need positive reinforcement in this area.)

D. Decisions
(NOTE: There will be times when you are asked directly for advice and/or be tempted to give it. Be careful! Offering alternatives and helping the girl examine her own feelings and situation is a far better approach.)

E. Advice givers
(NOTE: At times, a pregnant teenager feels bombarded with advice, much of it conflicting. She needs support and encouragement in making decisions and following through with them.)

V. Suggested Methods

A. Student activities: Have the student(s)
1. view slide presentation made by New Futures School students.
2. keep a diary of thoughts, feelings, questions, needs, etc.
3. complete open-ended questions on cards; cards are then collected and redistributed, so that student reads aloud another's reactions.

"When I first found out I was pregnant, I....."

"Now that I'm pregnant, I feel....."

"When I look at my body, I see....."

"The hardest decision I've had to make about pregnancy is....."

"When people give me advice, I....."

(NOTE: These questions will also be worked on individually on the study guide sheet.)

4. make a collage using magazine pictures to express own feelings about body.
5. write, or in teams of two, tell what part of her appearance she a) least likes, b) most likes, and c) would change if she could.
6. fill in chart called "What People Want Me To Be Like" on Study Guide. Discuss the problems caused by people's different expectations.
7. individually, or in small groups, share their responses to the following questions:

"When you need help, where do you go...
...for school problems?
...for personal problems?
...for friend problems?
...for family problems?

(NOTE: Encourage students to share the wide range of help available and list on blackboard.)

8. talk for one full minute to her partner about all of her good qualities while partner listens attentively. Switch.
(NOTE: Students may think this is embarrassing, but it is good for their self-esteem. You may want to list areas of their lives in which they normally put themselves down: physical, mental, familial, sexual, social, etc.

9. complete study guide.

B. Teacher activities: The teacher can invite a counselor, minister, or other helping person to speak on the value of seeking help with problems.

VI. Resource Materials

A. NFS slide-tape, "*I'm Not Bad, Just Pregnant*."

B. Student reading: *Only Human*; *Mr. and Mrs. BoJo Jones*

C. Teacher reading: *Only Human*; *The Teenage Pregnant Girl*; *Adolescent Pregnancy and Childbearing - Growing Concerns for Americans* (Population Bulletin); *School-Age Parenthood* (Bulletin); "The Social Consequences of Teenage Parenthood"; "Pregnant Teenagers: Needs and Services"

Chapter Two

"Understanding Human Reproduction"

I. Objectives

A. To provide information about the anatomy and physiology of the female reproductive system.

B. To provide information about the male reproductive system.

C. To encourage and guide personal exploration of values related to the handling of sexual feelings.

II. Generalizations

A. Knowledge of normal reproductive anatomy and physiology can favorably influence the reproductive experience.

B. Information about the reproductive system contributes to a positive body image and fosters responsible health care.

C. The individual's own value system will determine to a large extent the manner in which sexual feelings are handled.

III. Student Objectives: The student will be able to

A. Draw a picture and label each part of the female reproductive organs.

B. Explain the function of the ovaries, Fallopian tubes, cervix, vagina and uterus.

C. Define ovum.

D. Explain what menstruation is.

E. Explain what ovulation is and when it occurs.

F. Define fertilization.

G. Define nocturnal emission and erection.

H. Identify and explain the function of the penis, testicles, scrotum, vas deferens, seminal vesicles, urethra and bladder.

I. Explain the male's role in human reproduction.

J. Be able to discuss the question, "Do you believe teenagers who are not married should have sex?"

IV. Content

A. Female anatomy
   1. ovary
   2. Fallopian tube
   3. uterus
   4. cervix

   5. vagina
   6. ovum

B. Female reproductive cycle
   1. ovulation
   2. menstruation
   3. fertilization

C. Male anatomy
   1. penis
   2. testicles
   3. scrotum
   4. vas deferens
   5. seminal vesicles
   6. urethra
   7. bladder
   8. sperm

D. Male sexual functioning
   1. secondary sex characteristics
   2. nocturnal emission
   3. erection
   4. ejaculation
   5. semen

E. Human sexuality
   1. sexual intercourse
   2. sexual feelings

(NOTE: We have found that our students often have a very limited understanding of reproductive anatomy and physiology. This basic information is essential for the understanding of the maternity cycle and contraception.)

V. Suggested Methods

A. Student activities: Have the student(s)

1. before studying material, sketch what she believes her reproductive system to look like. Repeat after study to compare differences. (NOTE: This activity may also be done for male reproductive system.)
2. view films and/or filmstrips on reproductive physiology.
3. respond verbally or in writing to this question to Dear Abby:

   "Dear Abby: My mother says it's wrong to have sex before marriage. My friends are doing it, and my boyfriend wants to. What should I do?"

   (NOTE: This question is also on the Study Guide. Discussions related to sexual activity may bring forth feelings of guilt in some students. Focus on sexual decision-making now and in the future. Encourage acceptance and release of the past.)

4. complete study guide.

B. Teacher activities: The teacher can invite a qualified speaker (counselor, family planning specialist, etc.) to discuss human sexuality.

VI. Resource Materials

A. Films, *Human Reproduction*, *Human Growth II*

B. Filmstrips, *Human Reproduction Series*

C. Slides, *Understanding Conception and Contraception*

D. Student reading: *Inside Mom*, pp. 10-13; pamphlet, "M.A.S.H., Mostly About Sex and Other Hassles"

E. Teacher reading: *Understanding Conception and Contraception*; *Our Bodies Ourselves*; *Understanding Human Sexuality*; *Human Sexuality*

(NOTE: We realize that the study of human sexuality encompasses far more than the information included in this chapter. We have included only that which is necessary for the understanding of pregnancy, childbirth and contraception. The teacher may wish to expand course content here or following the study of pregnancy and childbirth.)

Chapter Three

"Your Visits To The Doctor"

I. Objectives

- A. To motivate the young mother to obtain early and continued health care.
- B. To provide information about prenatal medical care and to promote the establishment of a working relationship between the patient and health care providers.

II. Generalizations

- A. Early and continued prenatal care by a qualified physician or nurse-midwife is of extreme importance to the health of both mother and unborn baby.
- B. Teenage mothers are often at risk nutritionally and a weight gain of twenty-four to thirty pounds is recommended.
- C. The better informed the patient, the more she can benefit from medical care and relate to health care providers.
- D. The teenage girl is at risk medically in pregnancy due to physical, maturational and emotional immaturity.

III. Student Objectives: The student will be able to

- A. Explain the importance of early and continued prenatal care to mother and unborn baby.
- B. List four blood tests which are done at the beginning of pregnancy.
- C. Define desirable weight gain in pregnancy and describe the dangers of inadequate weight gain.
- D. List four reasons why the doctor does a pelvic examination at the first prenatal visit.

IV. Content

- A. Importance of prenatal care
- B. Medical history
  1. health questions
  2. menstrual history
- C. Blood tests
  1. VDRL
  2. hemoglobin
  3. blood type
  4. Rh factor
  5. Rubella titer

((NOTE: It will be helpful for the teacher to increase her knowledge of the purpose of the above tests.)

D. Weight
   1. normal weight gain
   2. breakdown of 24 to 30 pounds

E. Blood pressure

F. Urine test

(NOTE: Sugar in the urine can indicate a pre-diabetic condition. The presence of albumen may be indicative of toxemia.)

G. Complete physical exam

H. Pelvic exam
   1. signs of pregnancy
   2. signs of infection
   3. Pap's smear
   4. gonorrhea test
   5. pelvic measurements

(NOTE: Students may be afraid to mention signs of infection to their doctors. This is due to the fear that they may have a serious venereal disease, rather than the more common forms of infection. It is important to stress that all infection can and should be treated.)

I. Return visits

J. Importance of asking questions

(NOTE: Students often have difficulty asking doctors questions. We suggest that they make lists of their questions and concerns.)

V. Suggested Methods

A. Student activities: Have the student(s)
   1. think back on first visit to the doctor. Discuss, as if on "guided tour", what went on, feelings, and the importance of the procedures. (NOTE: Many women feel embarrassed and shy as patients, and for this reason, often avoid medical care. Emphasize naturalness and importance of relaxation.)
   2. role-play doctor's visits.
   3. calculate EDC ("due date").

(Example: first day of last menstrual period = June 10
add 7 days + 7
17
subtract 3 months - 3 months
EDC = March 17

   4. complete study guide.

B. Teacher activities: The teacher can invite a doctor or midwife to class to discuss prenatal care.

VI. **Resource Materials**

A. Films, *Your Pelvic and Breast Exam*; *While You Are Waiting*; video-cassette, *The Pap Test and Self-Breast Examination*

B. Student reading: *Be Good To Your Baby Before It's Born*, p. 3. (pamphlet)

C. Teacher reading: *Your Pregnancy Month by Month*

Chapter Four

"Two Stories At Once"

I. Objectives

A. To discuss fetal development from conception to birth, emphasizing the importance of the first trimester.

B. To explain the physiological changes occurring in the mother's body from conception to birth.

II. Generalizations

A. The first twelve weeks of pregnancy is the most critical time in the development of the fetus.

B. The baby grows more rapidly during prenatal life than he ever will again.

C. Understanding normal physiological changes helps the mother adapt to the experience of pregnancy.

III. Student Objectives: The student will be able to

A. Explain why the first 12 weeks of pregnancy are so important in the baby's development.

B. Explain what the placenta is and describe its function.

C. Explain the purpose of the bag of water.

D. Describe the baby's development at 3 months, 5 months, 7 months, and 9 months.

E. List five physiological changes expected in the mother during pregnancy.

F. Define implantation, embryo, umbilical cord, amniotic sac, amniotic fluid, colostrum, quickening, lanugo, vernix, engagement.

IV. Content

A. Fetal development - first three months
   1. fertilization
   2. implantation (conception)
   3. cell division
   4. embryo - all body organs formed
   5. fetus - name changed when bone starts forming; sex can be determined from visual inspection
   6. importance of early months emphasized

B. Fetal development - fourth through ninth months
   1. quickening at fourth month (feeling of movement)
   2. skin protection: lanugo and vernix
   3. activity and abilities of fetus
      (a) swallowing and hiccoughing
      (b) thumb-sucking
      (c) breathing movements
      (d) development of senses
      (e) somersaults and movement

C. Placental development
   1. description and function
   2. umbilical cord
   3. amniotic sac and water (bag of water)

D. Physical changes in mother
   1. elevation of hormone levels of estrogen and progesterone
      (a) amenorrhea (menstruation ceases)
      (b) fatigue
      (c) emotional changes
      (d) urinary frequency
      (e) nausea and vomiting
      (f) breast changes
      (g) skin changes
   2. enlargement of uterus
      (a) pressure on bladder until fourth month when uterus rises from pelvis
      (b) pressure on internal body systems: digestive, circulatory, and respiratory
      (c) Braxton-Hicks contractions (painless "warm-up" contractions)
      (d) skeletal changes ("waddling")
      (e) engagement during last month ("dropping" - "lightening")

(NOTE: The changes in the mother's body are mentioned here to help the student grasp the concept that the baby is a part of her body and has an effect on it. Also, it helps the young mother to begin to understand how her body accommodates the growth of the fetus. For a more complete discussion of the common complaints related to the physical changes, see Chapter 5, "Keeping Yourself Well During Pregnancy".)

V. Suggested Methods

A. Student activities: Have the student(s)
   1. view film and filmstrip on normal fetal development
   2. read and report on the stage of development of her own baby.
   3. listen to cassette of sounds inside the womb.
   4. imagine what it is like to be a developing fetus: write, draw, or discuss from fetus' point of view.
   5. draw pictures of the fetus at various stages of development
   6. draw maternal growth of uterus, breasts, etc.

7. complete study guide.

B. Teacher activity: The teacher can discuss the changes experienced by mother during pregnancy, with emphasis on early clues of pregnancy, body changes, quickening (early sensations of fetal movement), engagement (dropping of baby).

VI. Resource Materials

A. Filmstrip, *Life Before Birth*, parts 1 and 2

B. Film, *Biography of the Unborn*

C. Cassette, *Lullaby from the Womb*

D. Student reading: *Inside Mom*, pages 15-63; *Your Pregnancy* (pamphlet)

E. Teacher reading: *From Conception to Birth*; *The Secret World of the Baby*; *A Baby is Born*; *A Child is Born*

(NOTE: Although the reading level of these books may be too high for some students, they will find the pictures of fetal development very informative and interesting.)

Chapter Five

"Keeping Yourself Well During Pregnancy"

I. Objectives

A. To provide accurate information needed to understand and cope with the physical changes and common complaints related to pregnancy.

B. To promote the practice of good prenatal care for greater comfort and stability during pregnancy.

II. Generalizations

A. Pregnancy and childbirth are normal functions of the human female.

B. The health of the pregnant individual and her unborn child are dependent to some extent on her knowledge of normal body functions and sound health practices.

C. The normal physical changes of pregnancy may be accompanied by annoying symptoms and complaints.

D. Many of the common complaints of pregnancy can be treated by dietary changes, exercise, and sleeping position.

III. Student Objectives: The student will be able to

A. Explain personal care related to rest, bathing, clothing, breasts, teeth, work, travel, sexual relations, exercise and sports, and douching.

B. List four common discomforts of pregnancy which can be helped by changes in diet, and outline the changes necessary.

C. List three common discomforts of pregnancy which can be helped by prenatal exercises and body position.

IV. Content

A. Personal care
  1. rest and sleep
  2. bathing
  3. clothing
  4. breast care
  5. teeth
  6. work
  7. travel
  8. sexual intercourse
  9. exercise and sports
  10. prenatal exercises (NOTE: Complete content and instructions are provided in the exercise booklet. It is a good idea to begin instruction and practice at this time.)

11. douching
    (NOTE: Many doctors do not recommend douching, as it cleanses away normal secretions which help prevent infection. However, for religious and cultural reasons, women may prefer to continue this practice.)

B. Common complaints
   1. nausea and vomiting
   2. dizzy spells
   3. frequent urination
   4. constipation
   5. heartburn
   6. muscle cramps
   7. backache
   8. vaginal discharge
   9. stretch marks
      (NOTE: Students may attempt to restrict weight gain to prevent stretch marks. Since they are caused by hormonal changes affecting the elasticity of the skin, it should be emphasized that such attempts will not work.)
   10. stuffy nose
   11. varicose veins
   12. hemorrhoids
   13. shortness of breath

C. Pregnancy as a natural, healthy condition
   1. discomforts are not danger signs.
   2. average individual will experience only a few discomforts.
   3. prevention and alleviation of discomforts are usually related to diet, rest, posture, and exercise - NOT medication.

V. Suggested Methods

A. Student activities: Have the student(s)
   1. write anonymous questions on slips of paper, answer as a group aloud. (NOTE: This is helpful for questions related to love-making.)
   2. make posters about personal care by cutting out or drawing pictures. (Example: safe or unsafe sports; comfortable versus restrictive clothing; etc.)
   3. visit second-hand stores and/or maternity shops to compare prices.
   4. examine samples of supportive bras and nursing bras. (NOTE: Undergarment salespersons are willing to lend these for classroom purposes.) Discuss best methods of putting on bras.
   5. examine labels on paints, cleaners, etc. for warnings.
   6. complete study guide.

B. Teacher activities: The teacher can

1. distribute 3"x 5" cards, each containing a question related to personal care or common complaints. Students answer on the card. Cards are collected and redistributed, so that students read aloud someone else's answer and discuss as a group. (NOTE: This minimizes the fear of being wrong.)
2. demonstrate exercises that alleviate complaints, then have student practice the exercises.
3. borrow maternity clothes from stores for students to model and discuss in class. (NOTE: Stores are usually very cooperative about this.)
4. discuss creative ways of adapting regular clothes for maternity wear. (NOTE: Often you can get donations for this purpose and students enjoy it.)
5. invite a dentist to talk to the class about dental care during pregnancy.
6. encourage students to offer suggestions as to other remedies and common folk beliefs. (NOTE: An atmosphere of acceptance is essential here! Don't discount beliefs. It is helpful to research this topic ahead of time.)

VI. Resource Materials

A. Slide series, "Straight Talk About Pregnancy"

B. Student reading: Be Good To Your Baby Before It's Born (pamphlet); Care For You And Your Baby To Be (pamphlet); What To Do About Minor Discomforts of Pregnancy (pamphlet)

C. Teacher reading: Sexual Relations During Pregnancy and the Post-Delivery Period (pamphlet); Your Pregnancy Month by Month

Chapter Six

"Be Good To The Baby Before He's Born"

I. Objectives

- A. To provide information regarding potential dangers to the unborn baby.
- B. To alert the expectant mother to the danger signs of pregnancy.
- C. To explore common misconceptions regarding pregnancy and childbirth.

II. Generalizations

- A. How an expectant mother takes care of herself relates directly to the outcome of pregnancy.
- B. Early detection and reporting of the danger signs in pregnancy may prevent serious medical problems for the mother and baby.
- C. There is scientific evidence to indicate that alcohol intake, smoking, drugs, x-rays, venereal disease, rubella, and dietary deficiencies can adversely affect fetal outcome.

III. Student Objectives: The student will be able to

- A. List six dangers to the unborn baby and their possible effects.
- B. List eight danger signs of pregnancy that should be reported to the doctor.
- C. List three misconceptions related to pregnancy and childbirth.

IV. Content

- A. Dangers to developing fetus
  1. smoking
  2. drugs
  3. alcohol
  4. x-rays
  5. venereal disease
  6. rubella and other infectious diseases
  7. dietary deficiency

  (NOTE: The teacher needs to research these topics further. New information on the adverse effects of the above dangers is continually being released.)

- B. Warning signs
  1. swelling in face, hands, and/or feet
     (NOTE: This sign is an indication of fluid retention and may indicate toxemia.)
  2. blurred vision, spots before the eyes
     (NOTE: This sign may be indicative of high blood pressure and possibly toxemia.)

3. bleeding from the vagina
   (NOTE: Bleeding can be a sign of miscarriage or placental dysfunction.)
4. severe or constant headaches
   (NOTE: Headaches can also be a sign of high blood pressure or toxemia.)
5. severe or continuous vomiting
   (NOTE: Vomiting can lead to dehydration and dietary deficiencies.)
6. fever and chills
   (NOTE: Fever may indicate an infection.)
7. burning and pain upon urination
   (NOTE: This sign usually indicates a bladder or kidney infection.)
8. sharp constant pain in abdomen
   (NOTE: This is a possible sign of toxemia.)
9. sudden gush or steady trickle of fluid from vagina
   (NOTE: This may indicate premature breaking of bag of water.)

C. Common misconceptions related to pregnancy and childbirth

(NOTE: There is a thin line between acceptable cultural beliefs and harmful misconceptions. It is necessary to dispel only those beliefs that have dangerous implications for either the mother or her baby. Attempt to incorporate cultural traditions with sound health care practices.)

V. Suggested Methods

A. Student activities: Have the student(s)

1. answer one or more of the following letters:

   (a) "I am pregnant and smoke a pack of cigarettes a day. Will this hurt my baby? If so, how? What should I do?"

   (b) "I had x-rays during my sixth month of pregnancy. Could this have hurt my baby? If so, how?"

   (c) "I am addicted to heroin. What does this do to my baby? Is there anything I should do?"

   (d) "I am a heavy drinker on the weekends. Can this harm my baby? What do you think I should do?"

   (e) "My boyfriend says he has gonorrhea, but I don't have any signs. Could I have it? Could it hurt the baby? How? What should I do?"

   (f) "I am pregnant and my little brother has German measles. I've heard that can hurt my baby. Is it true? What should I do?"

(g) "I live on cokes, candy, and potato chips. Does this hurt my unborn baby? What do you think I should do?"

(NOTE: Use pamphlets as student resources for this activity. Share responses in classroom.)

2. discuss in pairs what each is doing to help make sure her baby will be born healthy.
3. view films on dangers to the unborn baby and preventive measures.
4. complete study guide.

B. Teacher activity: The teacher can
1. invite speakers to talk to the class on V.D., alcohol, drugs, smoking, etc. Or, the student can visit and report individually.
2. encourage students to discuss other things they have heard about pregnancy or that will affect the unborn child.
   (NOTE: An atmosphere of acceptance is very important. The students' beliefs must not be discounted. However, an open discussion can help in dispelling erroneous information.)

VI. Resource Materials

A. Films: The Choice; Have A Healthy Baby

B. Filmstrip/cassette: Tomorrow Happens Today
(NOTE: This very graphically shows the harm to the unborn baby from German measles, syphilis, thalidomide, etc. Preview before showing and follow with a reassuring discussion.)

C. Student reading: Be Good To Your Baby Before Its Born and other March of Dimes pamphlets.

D. Teacher reading: Same as students. (NOTE: Our emphasis is on the normal and natural. We have chosen not to discuss the complications of toxemia or miscarriage in any detail. You may have questions from students in these areas which would best be referred to their doctors.)

Chapter Seven

"Eating For Two"

I. Objectives

A. To teach the nutritional needs of the pregnant teenager, emphasizing the benefits for both mother and child.

B. To describe the requirements for a well-balanced diet for the pregnant adolescent.

C. To motivate the young mother to practice good eating habits.

II. Generalizations

A. The well being of the developing fetus is dependent to some extent on the nutritional status of the mother.

B. Nutritional status is one of the primary factors affecting maternal health and recovery.

C. The pregnant teenager needs to be especially careful to eat a good diet because: her own body is still growing; she may be in poor nutritional health at the beginning of pregnancy; she has an increased risk of toxemia; and she has an increased risk of premature delivery or delivery of a low birthweight baby.

III. Student Objectives: The student will be able to

A. List four reasons why a good prenatal diet is beneficial to the pregnant teenager.

B. List four reasons why a good prenatal diet is important for the baby.

C. List the number and size of servings needed by a pregnant teenager of milk and milk products; meat and other protein foods; fruits and vegetables; breads and cereals; water.

D. List good food sources of iron, protein, calcium, folic acid, and Vitamin C.

E. Explain the importance of calcium, iron, protein and folic acid in pregnancy.

F. Plan a well balanced diet for one day, incorporating her own food preferences.

IV. Content

A. Importance of good nutrition
  1. food is needed for growth
  2. benefits to mother
  3. benefits to baby
  4. frequently asked questions related to prenatal nutrition

B. Nutritional needs of the pregnant adolescent
  1. milk and milk products
    (a) four to five servings daily
    (b) provides calcium, protein, Vitamin D and Vitamin A
  2. meat and other protein foods
    (a) three or more servings daily
    (b) provides protein, iron, folic acid and B Vitamins
    (c) vegetable protein is more readily utilized by the body when accompanied by a small amount of animal protein, such as milk or cheese (examples: pinto beans with cheese, black-eyed peas with ham hocks, etc.) (NOTE: Vegetable protein is less expensive and makes a valuable contribution to dietary intake.)
  3. fruits and vegetables
    (a) four to five servings daily
    (b) Vitamin C, at least one serving daily
    (c) Vitamin A, at least one serving daily
  4. breads and cereals
    (a) five to six servings daily
    (b) provides B vitamins and iron
  5. water
    (a) six to eight (8-oz.) glasses daily
    (b) provides body fluids needed for waste elimination, increased blood supply, added tissues, and absorption of nutrients

C. Vitamins and minerals essential for body growth and repair
  1. calcium for bones, teeth, nerves and muscles
  2. Vitamin D for use of calcium and prevention of rickets
  3. Vitamin A for eyes, skin, hair, and normal body growth
  4. Vitamin C for general resistance to infection, teeth, gums, bones, body cells and blood vessels
  5. B vitamins for nerves, appetite and utilization of other nutrients
  6. folic acid for absorption of iron
  7. iron for production of red blood cells and prevention of anemia; stored in fetus' body during latter months of pregnancy
  8. protein for building and repair of body tissues, brain, and blood

D. Special food tips for pregnancy

(NOTE: This is a list of some of the major points related to sound eating and buying habits. It is by no means complete. The teacher is encouraged to expand upon concepts related to meal planning and preparation as well as consumer buying.)

V. Suggested Methods

A. Student activities: Have the student(s)
  1. view films on normal nutrition and nutrition in pregnancy, followed by a discussion of the importance of good nutrition.

2. record all of the food eaten on a particular day and then check the appropriate column for the reason why the food was eaten.

Food Eaten Today	Reasons for eating that food				
	Hungry & it was available	Served to me	Everyone else did	To lose weight	To gain weight
1.					
2.					
3.					

Other reasons:	To Be healthy	To have something to do	I was nervous or upset

(NOTE: What we eat is often related to how we feel about ourselves. Completing this chart will help the student better understand herself and why she eats what she does.)

3. volunteer to list what she ate the day before (or use your own diet) and put it on the board. As a group, decide which food groups each food fits into. Count the number of servings in each group and compare this with the number required. If any of the food groups are not adequate in number of servings, have the students decide what could be added to make the diet complete.)
4. solve this problem:

   Polly is pregnant and doesn't like milk. Think of four other ways she can make sure she still gets enough of this food group in her diet.

5. make two lists of snacks. On the left, include all snacks that are nutritious. On the right include snacks that have only "empty calories" and no nutritional value. To decide if a snack is nutritious, have the student refer to the food chart in her book.
6. write a letter giving a teenager advice about her eating habits during pregnancy. Tell her why she should follow your advice.
7. discuss (in writing, with another student, or with you) what changes she would like to make in her eating habits.
8. plan well-balanced meals using foods from the various cultural groups represented in the class. If the facilities are available, students enjoy preparing and sampling the foods. Let the students become your experts in this area.

   (NOTE: At first students may be embarrassed by their ethnic food preferences and reluctant to discuss them. This is an excellent opportunity to emphasize that all cultural traditions incorporate foods that provide for adequate nutritional intake.)

9. view films on consumer buying tips and discuss.
10. complete study guide.

B. Teacher activity: The teacher can invite a nutritionist to talk about food stamp, WIC and other food programs.

VI. Resource Materials

A. Filmstrip and cassette: Inside My Mom

B. Films: Great Expectations; Nutrition: The Inner Environment; Super Goop; Read the Label, Set a Better Table; Eat, Drink, and Be Wary

C. Basic Four Food Charts, food models, food comparison cards, and pamphlets - available from Dairy Council of the Rio Grande.

D. Student reading: Food for the Teenager During Pregnancy (pamphlet); Nutrition In Pregnancy (pamphlet)

E. Teacher reading: Nourishing Your Unborn Child; The Pregnant Cook's Book; The Mother's Cook and Cope Book

Chapter Eight

"Making Decisions For You and Your Baby"

I. Objectives

A. To encourage self-awareness and self-understanding as a basis for sound decision-making.

B. To assist in the exploration of choices related to teenage pregnancy.

C. To present the steps in the decision-making process.

II. Generalizations

A. No one decision is right for everyone, because each individual's circumstances are different.

B. Decision-making is facilitated by self-exploration and gathering of information.

C. Decision-making is both a cognitive and an affective process.

D. Making decisions is facilitated by following the orderly steps in the problem-solving process.

III. Student Objectives: The student will be able to

A. List the reasons for and against at least two of the alternatives available to the pregnant adolescent.

B. Demonstrate the use of the steps in the problem-solving process by applying them to a problem situation of her choice.

IV. Content

A. Exploring choices related to adolescent pregnancy
  1. keeping versus releasing the baby
    (a) what parenthood involves
    (b) personal goals
    (c) planning for a baby
    (d) reactions to releasing a baby for adoption
    (e) reactions of significant others

(NOTE: Discussions about adoption may lead to heightened emotion and even arguments that may extend beyond the classroom. Students need help in learning to respect the decisions of others.)

  2. questions and concerns related to teenage parenthood
    (a) "trying on" the idea of parenthood
    (b) preservation of personal identity
    (c) involvement of grandparents
    (d) single parenthood
    (e) social life
    (f) feelings related to release of a child

3. marriage versus single parenthood
    (a) readiness for marriage
    (b) relationship between partners
    (c) personal values and goals
    (d) "trying on" the role of wife

(NOTE: Many girls feel that marriage will be the answer to all their problems. Married girls tend to flaunt their position until they have problems. The divorce rate among married teens is significantly higher than in the population as a whole.)

B. Problem-solving process
  1. gathering information
  2. listing alternatives
  3. evaluating the advantages
  4. evaluating the disadvantages
  5. making a choice
  6. living peacefully with your choice

(NOTE: The number of choices available to some students is often quite limited. This is often true of the younger teen who is still dependent upon her parents. The student needs to be helped to accept this and learn to live with her situation.)

V. Suggested Methods

A. Student activities: Have the student(s)
  1. view films related to teenage pregnancy.
  2. make lists under each of these headings:
    (a) what my family wants me to do
    (b) what my boyfriend wants me to do
    (c) what my friends want me to do
    (d) what I want to do

(NOTE: This may be about anything. Discuss difficulties related to pleasing everyone.)

  3. interview single mothers (or have a panel) to learn about their experiences.
  4. write a personal want ad for "your perfect mate". Students should do these individually (and anonymously). They may be hung up in the classroom and you may utilize them to lead into class discussion. ((NOTE: Differences in preference should be treated with respect.)
  5. interview two married couples (preferably one older couple and one younger couple). Find out about the roles the partners play in the marriage, parenthood, etc. Compare the differences.
  6. play the game called "The Game of Life" to help students learn to make choices related to life goals.
  7. complete study guide.

B. Teacher activities: The teacher can
  1. discuss the steps in the decision-making process. Show how the principles work by applying them to a sample problem; i.e. whether or not to marry, career choices, etc.
  2. invite an adoptive parent to speak.

VI. Resource Materials

A. Films: I'm Seventeen and Pregnant; Growing Up Together

B. Slide/tape: I'm Not Bad, Just Pregnant

C. Student reading: Parenting: A Guide for Young People, pp. 5-27, 155-156; Only Human

D. Teacher reading: A Handful of Hope (pamphlet); Am I Parent Material? (pamphlet); Only Human

Chapter Nine

"What To Expect In The Hospital"

I. Objectives

A. To reduce fear and develop confidence by becoming familiar with what can be expected during the hospital experience.

B. To stress the importance of the mother-infant interaction during the hospital stay as a basis for developing a strong parent-child relationship.

II. Generalizations

A. The quality of the hospital experience can be favorably influenced by a knowledge of hospital procedures and policies.

B. The quality of maternal-infant bonding in the immediate post-partum period can have a profound effect on the future relationship of mother and child.

III. Student Objectives: The student will be able to

A. Describe when the woman in labor should go to the hospital, where she should first go, and what she should take with her.

B. Explain what a "prep" and enema are and why each is done in preparation for delivery.

C. Explain why the woman in labor should not eat a large meal.

D. Explain how the mother is assured of adequate fluid intake during labor and delivery, even though hospital routine usually does not allow her to eat or drink during labor.

E. Explain what the episiotomy is and why it may be done.

F. Describe the care given to the newborn in the delivery room.

G. Define: forceps, circumcision.

H. Describe the procedures needed during the first hour after delivery, and be able to explain the purpose and importance of the massage of the uterus.

IV. Content

A. When to go to the hospital

B. Where to go

C. What to take

D. Hospital procedures and care
1. admission
    (a) preliminary examination
    (b) prep
    (c) enema
2. labor room
    (a) restricted food and liquid intake
    (b) I.V.
    (c) vaginal examinations
    (d) breaking of bag of water
    (e) visitors
    (f) fetal monitor
3. delivery room
    (a) preparation for delivery
    (b) equipment
    (c) episiotomy
    (d) mother-infant contact
    (e) placenta
4. care of the baby
    (a) identification bands
    (b) Krieselman (warmer)
    (c) initial exam
    (d) weight and measurement
    (e) eyedrops to prevent gonorrheal infection (silver nitrate or penicillin)
    (f) suctioning of mucus from nose and throat
    (g) clamping of cord
5. recovery room
    (a) importance of care during the first hour
    (b) blood pressure
    (c) pulse
    (d) massage of uterus for control of bleeding
    (e) pads checked for amount of bleeding
    (f) ice pack for stitches
    (NOTE: In some hospitals, this may not be done.)
    (g) food, if desired
6. postpartal stay
    (a) one to three days
    (b) walking with assistance
    (c) showers
    (d) sitz bath
    (e) baby care classes
    (f) visitors
    (g) exercise
    (h) mother-infant interaction
    (NOTE: The importance of the first hours and days should be stressed. The psychological process of mother-infant attachment is greatly facilitated by early close contact.)

(i) the mother who releases
(NOTE: Stress the difficulty of making decisions related to adoption during the hospital stay. If these decisions have not been made prior to delivery, they are best postponed until the mother's condition has stabilized. The decision of whether or not to see the baby in the hospital is a highly individual matter. The mother should not be influenced regarding this decision, as her adjustment may be dependent upon her choice.)

7. Birth certificate
   (a) required by law
   (b) importance of obtaining a copy
8. Circumcision
   (a) surgical removal of foreskin
   (b) preferences are closely related to familial, religious, and cultural background.
   (NOTE: This procedure is no longer considered medically necessary.)

V. Suggested Methods

A. Student activities: Have the student(s)
   1. view film on the labor and delivery experience in the hospital. (NOTE: It is best to use a film that emphasizes the hospital care rather than the delivery experience.)
   2. discuss with their doctor or midwife the type of mother-infant interaction that is allowed following delivery, and why.
   3. view film on mother-infant interaction following delivery and discuss why it is important.
   4. complete study guide.

B. Teacher activities: The teacher can
   1. have a certified nurse-midwife and/or partera discuss how the home-birth or maternity center experience is different from a hospital delivery.
   2. arrange for a tour of the labor and delivery facilities of a local hospital.
   3. invite a labor and delivery room nurse to talk to the students and answer questions.

VI. Resource Materials

A. Film: Lynn and Smitty; The Bonding Birth Experience

B. Student reading: Most hospitals have a brochure or written instructions regarding hospital stay. Both students and teachers should familiarize themselves with these materials.

C. Teacher reading: Maternal-Infant Bonding; "Maternal Tasks in Pregnancy" (article)

(NOTE: We have chosen to discuss the procedures of a hospital delivery, as teenage mothers are in the high risk medical category. Some mothers may choose to explore alternative methods of delivery, such as maternity centers or home delivery. In these cases, the importance of the presence of a trained nurse-midwife should be emphasized.)

Chapter Ten

"Being Comfortable During Labor"

I. Objectives

- A. To discuss the importance of preparation as a favorable influence on the childbirth experience.
- B. To provide information about the most commonly used types of analgesia and anesthesia for labor and delivery.

II. Generalizations

- A. Fear of the unknown or unfamiliar may unfavorably influence the progress of labor and delivery.
- B. Knowledge and use of relaxation and breathing techniques can favorably influence the progress of labor and delivery.
- C. The concept of "informed consent" is based on the patient's knowledge of and agreement to the nature of surgical and/or anesthetic procedures.

III. Student Objectives: The student will be able to

- A. Explain what "natural childbirth" means.
- B. List two advantages of being prepared for childbirth.
- C. Explain the role of the labor "coach".
- D. Define analgesia and anesthesia.
- E. List each type of anesthesia for labor and delivery; describe the area of the body which each type numbs.
- F. Explain why gas (general) anesthesia is not commonly used for normal childbirth.

IV. Content

- A. "Natural childbirth" means prepared childbirth.
  (NOTE: Some people use this term to refer to having a child out of wedlock.)
  1. purpose of preparation
  2. exercises for breathing, relaxation, and body conditioning
     (NOTE: Refer to Exercise Booklet for complete details.)
- B. Fear, tension, pain cycle
- C. Childbirth classes
  1. type of exercises and breathing techniques taught vary
  2. importance of practice
     (NOTE: Because availability of classes differs in each community, check with the local hospital or doctors for more information.)

D. Labor coach
    1. role during labor
    2. choice of this person
    3. hospital personnel may provide assistance in the absence of a coach

E. Cesarean section
    1. reasons for this procedure
        a. pelvic structure too small to accommodate passage of baby's head
        b. progression of labor stops prematurely
        c. placenta previa - placenta positioned over cervical opening
        d. placenta abruptio - premature separation of placenta from uterine wall

    (NOTE: Abnormalities in the progression of labor have not been discussed in detail, as they are frightening to some students.)

F. Analgesia - administered to reduce pain and/or tension, usually by injection during active labor
    1. "pain killers"
    2. tranquilizers

    (NOTE: Students are frequently frightened by discussions related to the use of needles used in any procedure!)

G. Anesthesia - administered to block feeling or sensation in a part of the body
    1. general ("gas")
        a. limited use in normal deliveries because of danger of vomiting and aspiration in the mother
        b. can cause central nervous system depression in the newborn
    2. regional
        a. saddle block or spinal
            (1) administered immediately prior to delivery
            (2) numbs from waist to toes
            (3) blocks out the pushing reflex
            (4) delivery may be assisted by the use of forceps
            (5) may cause temporary inability to urinate

        (NOTE: Some hospitals require that the patient lie flat for six to eight hours after delivery. There is controversy as to whether or not this prevents a post spinal headache.)
        b. epidural or caudal
            (1) administered during the last half of the first stage of labor
            (2) numbs from waist to mid-thigh
            (3) blocks pushing reflex
            (4) delivery may be assisted by use of forceps
            (5) may cause temporary inability to urinate

        (NOTE: Special training is required for the administration of this type of anesthesia. Therefore, availability is variable.)

c. nerve blocks
   (1) paracervical
      (a) injected directly into cervix when patient is at least four centimeters dilated
      (b) reduces pain due to dilation of cervix
      (c) may be repeated periodically
   (2) pudendal
      (a) injected into the vaginal wall to numb perineum for episiotomy
      (b) often used with "natural childbirth"

(NOTE: The student's motivations and abilities to grasp these concepts differ greatly. They should be encouraged to discuss alternatives related to medication with their doctors or midwives.)

V. Suggested Methods

A. Student activities: Have the student(s)
   1. view films on prepared childbirth and the role of the coach.
   2. share their own experiences with labor and delivery and/or Cesarean section with emphasis on their preparation (or lack of).
   3. complete study guide.
   4. view film on Cesarean section (if this seems appropriate to the students' needs).

B. Teacher activities: The teacher can
   1. invite a midwife to talk to the class about her training and her role in labor and delivery.
   2. have a doctor (or midwife) talk about anesthesia
   3. invite a childbirth educator to talk about "natural childbirth" and selecting a "coach"

VI. Resource Materials

A. Films: Birth of a Family; Not Me Alone; The Cesarean Birth Experience

B. Slide/cassette: The Childbirth Experience

C. Student reading: Teenage Handbook for Prepared Childbirth

D. Teacher reading: Methods of Childbirth; Thank You, Dr. Lamaze; Childbirth Without Fear; Husband-Coached Childbirth; Preparation for Childbirth; Cuidado Prenatal y Preparacion para el Parto; The Cesarean Birth Experience; Birth

(NOTE: Students may be interested in the above books, and if their reading level is appropriate, should be encouraged to read them.)

Chapter Eleven

"Labor and Delivery"

I. Objectives

A. To reduce fear in the young mother by providing information about the physical and emotional processes of labor and delivery.

B. To help her prepare for and confidently anticipate normal labor and delivery.

II. Generalizations

A. The ability to cope with the stress of labor and delivery is favorably influenced by knowledge and understanding of the normal physiology of labor and delivery.

B. Labor and delivery progresses according to a standard sequence of physiological events, subject to individual variations of time.

C. The individual's physical and emotional condition influences the progress of labor and delivery.

III. Student Objectives: The student will be able to

A. List the first three stages of labor and describe what happens in the body during each stage.

B. List three of the beginning signs of labor.

C. Explain the differences between true and false labor.

D. Describe the transition phase of the first stage of labor and the symptoms which may accompany it.

E. Describe the role of the laboring woman during the first and second stages of labor.

F. Define: contraction, effacement, dilation, crowning, "fourth stage of labor".

IV. Content

A. Labor defined

B. Signs of labor
   1. bloody show
   2. rupture of bag of water
   3. regular contractions
   4. other signs may include sudden energy spurt, gas pains, diarrhea, and backache

C. Contractions
   1. tightening of the uterine muscles
   2. timing: length and interval

D. Distinguishing true from false labor

E. Stages of labor

1. First stage: from first true contraction to complete dilation of cervix (10 centimeters or 4 inches). This stage involves the effacement (thinning) and dilation (opening) of the cervix. The mother's feelings range from initial excitement to concentration on contractions to a deep sleep (amnesic state) at the end of the first stage. During transition, she is likely to feel threatened, fear losing control, and behave irritably. Her role during the first stage is to rest between contractions and relax during contractions to allow her uterine muscles to work efficiently.
2. Second stage: from complete dilation to delivery of baby. This is the stage of active participation in which the mother utilizes her abdominal muscles to push the baby down and out. She will probably be more awake and alert during this stage. The degree of her participation will be influenced by the type and amount of analgesia and/or anesthesia she has received.
3. Third stage: from delivery of the baby to expulsion of the placenta (afterbirth). During this short stage, the mother may experience the final contractions that cause the expulsion of the placenta. She may be interested in watching the care of her infant or may fall asleep from exhaustion.
4. Fourth stage: first hour after delivery. The uterus will contract and rise to the level of the navel. The mother may be sleepy, hungry, or excited. The abrupt change in internal body pressure caused by delivery may result in trembling or tears. The massage of the uterus to prevent hemorrhage may be very uncomfortable. The baby is awake and alert during this time and mother-infant contact is beneficial for the development of the parent-child bond. This should be encouraged whenever hospital policies allow.

V. Suggested Methods

A. Student activities: Have the student(s)

1. view films on labor and delivery.
2. interview three different mothers:
   a. one who gave birth within the past year,
   b. five years ago
   c. ten years ago

   compare their experiences.
3. share in pairs (or write a report):
   a. "How did you first learn about the birth of babies?"
   b. "Who told you?"
   c. "What did they tell you?"

4. role-play how they would tell a three-year-old, seven-year-old, and twelve-year-old child about how babies are born.
5. complete study guide.

B. Teacher activities: The teacher can

1. use the teacher aids listed under Resource Materials and explain the process of labor and delivery.
2. help students learn how to time contractions, by having a clock with a second hand available in the classroom. Announce at the beginning of class that you will be telling them throughout the class period that contractions are beginning and then when they end. Have the students record the time each contraction began and how long each one lasted. At the end of the class, look at the times and have students tell whether they are regular (sign of true labor) or irregular (false labor).

VI. Resource Materials

A. Teacher aids: Birth Atlas flipchart; Cervical Dilation chart. A balloon can be blown up inside a narrow-necked gallon jug (milk or cider jug) to illustrate the containment of the bag of water inside the uterus and the long, narrow cervix. To illustrate the dilation of the cervix to allow the passage of the baby, use a wide-mouth gallon jar (mayonnaise) and a small, flexible baby doll. (NOTE: We appreciate the creativity of Joyce Bradley for originating this idea.)

B. Film: Birthday

C. Student reading: Teenage Handbook for Prepared Childbirth; A Baby Is Born

D. Teacher reading: Refer to list provided in Chapter Ten.

"After The Baby Is Born...Now What?"

I. Objectives

- A. To discuss normal physical and emotional changes and care during the postpartum period.
- B. To provide anticipatory guidance to help the new mother cope with the early period at home.

II. Generalizations

- A. The process of postpartum involution follows a standard sequence of physiological events, subject to individual variations of time, initial physical condition, and quality of care provided.
- B. Recovery of normal body condition during the postpartum period is influenced by rest, nutritional status, exercise and personal hygiene practices.
- C. Normal hormonal changes during the postpartum period, and change in role/life style may cause emotional instability in the new parent.

III. Student Objectives: The student will be able to

- A. Name three changes which take place in the woman's body during the six weeks following childbirth.
- B. Name three things a new mother can do to facilitate recovery.
- C. Explain why the newly delivered mother has a bloody vaginal discharge (lochia) for three to six weeks after childbirth.
- D. Explain why some women experience depression following the baby's birth and three ways the woman can help herself during this time.
- E. Explain what happens at the postpartum check-up.
- F. Define: engorgement, "afterpains", involution.

IV. Content

- A. Physical changes and care during postpartum
  1. weight loss due to increased perspiration and urination
  2. regaining of muscle tone in abdomen and vagina
  3. appetite decrease
  4. involution of uterus
     - a. gradual return to normal size and position
     - b. no longer felt in abdomen after ten days
     - c. "afterpains" - more common in women who have had several children and who breastfeed

5. lochia
    a. secretion from the open wound at the site of placental attachment
    b. bloody vaginal discharge gradually changes from bright red to yellow
    c. usually disappears in three to six weeks
    d. cleanliness of perineum important
6. breasts
    a. non-breastfeeding mothers
        (1) receive medication to help prevent lactation
        (2) return to normal size in four to six weeks
    b. breastfeeding mothers
        (1) colostrum until milk production begins
        (2) lactation begins in two to four days after delivery
        (3) engorgement signals beginning of milk production
        (4) enlarged breasts throughout lactation period

    (NOTE: For more complete information on breastfeeding, refer to pamphlet.)

    c. supportive bras encouraged for both nursing and non-nursing mothers
7. healing of episiotomy
    a. stitches dissolve in one to two weeks
    b. continue soaking in warm water
    c. regular bowel movements facilitate healing and comfort
8. menstruation
    a. non-nursing mothers usually have period within 12 weeks
    b. nursing mothers may not have a period until lactation ceases
    c. ovulation can occur at any time after delivery

    (NOTE: Stress that pregnancy is a possibility even though the mother may not have had a period!)

9. postpartum check-up at four to six weeks

B. Resumption of normal activity
1. bathing may be resumed at any time
2. sexual intercourse should be delayed until all bleeding has stopped and episiotomy is healed.
3. naps and extra rest will be required until strength has been regained.
4. regular school and work activities may be resumed within two weeks if everything is normal.

(NOTE: In Spanish-speaking cultures, some girls are taught that they should not bathe or leave the house for an extended period of time following childbirth.)

C. Emotional adjustment
1. postpartum depression ("baby blues")
    a. caused by hormonal and psychological changes
    b. diversion is helpful

    2. maternal feelings
        a. develop gradually
        b. may not be as expected

V. Suggested Methods

- A. Student activities: Have the student(s)
    1. respond to the following letter:

    > "I had my baby ten days ago. Most of the time I am very happy and feel real good. Sometimes, I seem to cry for no reason at all. Is this normal? What can I do?"

    2. view film on postpartum experience
    3. complete study guide
- B. Teacher activities: The teacher can
    1. utilize the 3"x 5" question card technique (see Chapter 5, Suggested Methods). Questions should deal with changes and care during the postpartum.
    2. invite a panel of young women (one who kept her baby and is single, a young married, and one who released) to discuss their adjustments following childbirth.

VI. Resource Materials

- A. Film: Are You Ready for the Postpartum Experience?
- B. Student reading: Care for You and Your Baby-To-Be (pamphlet)
- C. Teacher reading: Now That You've Had Your Baby

(NOTE: We have found that there are often discrepancies in what we teach about care on a scientific basis and what will be practiced in the home, as there are many cultural beliefs regarding the care of a new mother. Encourage the students to share their own beliefs in a warm, accepting atmosphere without discounting beliefs. This may help her to integrate and practice sound health care.)

Chapter Thirteen

"Hello, Stranger!"

I. Objectives

A. To explain the characteristics of the newborn infant.

B. To emphasize the emotional needs of the infant and their importance during the early years of his life.

C. To discuss the physical needs of the young infant.

D. To help the mother understand that her baby is an individual whose needs may differ somewhat from those of other babies.

E. To provide simple, practical suggestions for meeting the physical and emotional needs of the young infant.

II. Generalizations

A. Newborn infants have some characteristics in common, the exact nature of which may vary from one infant to another.

B. Newborns have a need to develop a strong emotional attachment to at least one human being during the first year of life.

C. The development of a positive self-concept and a sense of trust in the infant begins at birth and is dependent upon consistent, nurturant care.

D. Each newborn is an individual with unique physical and personality characteristics which are determined by both genetic and environmental factors.

E. The parent's acceptance of and adaptation to the child's personality favorably influences the parent-child relationship and enhances the child's self-esteem.

III. Student Objectives: The student will be able to

A. Describe six physical characteristics which are common to most newborns.

B. List four things the infant is able to do at birth.

C. Explain what is meant by "tender, loving care" and why it is important to the infant.

D. List two important points to remember when meeting an infant's needs for: feeding, bathing, clothing, and health care.

E. List four immunizations a baby should receive.

F. List six important safety measures to follow when caring for an infant.

IV. Content

A. Newborn not always what the mother anticipates.

(NOTE: Prior to the baby's birth, the mother tends to fantasize her baby as looking and acting "ideal", almost as if the child were a doll. She needs assistance in adjusting to the realities of a real infant. The earlier the mother can identify with her infant and "claim" the baby as her own, the stronger will be the mother-child bond. Pointing out the desirable characteristics of the baby and the child's resemblances to the mother and other family members is helpful. However, be careful, because pointing out resemblances to persons the mother dislikes can create barriers between the mother and child!)

B. Common characteristics

1. head

a. one-fourth size of body as a result of early brain development in humans

b. molding caused by birth process

c. fortanel due to incomplete fusion of bones

(NOTE: In New Mexico, many people believe that a triangular handkerchief worn on the baby's head will make it round. Also, many people believe that touching the fontanel during the first month will prevent the bones from growing together.)

2. eyes

a. slate-blue because of incomplete pigmentation

b. swollen and runny from medication used to prevent infection

c. redness in and around eyes can be caused by birth process

d. tear ducts not functioning at first

e. crossed or wall-eyes due to lack of muscle coordination

(NOTE: Many mothers are fearful of looking at their babies from behind, because it might make them cross-eyed. Also, Mal de Ojo [explained in the text] results from continued eye contact. Other people believe that it is bad luck to hold a child in front of a mirror before he is one year old.)

3. flat nose, receding chin and short neck facilitate sucking

(NOTE: It is important to reassure students that this is normal and that chin and nose develop along with the sucking process.)

4. breathing is noisy, jerky and erratic

5. skin

(NOTE: Various cultures encourage different styles of skin care. The importance of skin care is stimulation of the infant.)

6. hair - early hair may fall out and/or change color
   (NOTE: Traditionally, some Pueblo Indians rub the newborn with ashes twice to rid them of body hair. Another practice has been to shave the baby's head, so that he will grow a thick head of hair.)

7. cord
   (NOTE: There are many cultural traditions related to cord care. Some of these include:

   ...belly binders with or without coin to prevent hernia and keep baby's back strong [Spanish-speaking]
   ...burning the umbilical cord gives the baby strong kidneys [Black]
   ...an infected cord is rubbed with dirt from an outside oven [Pueblo Indian]
   ...burying of umbilical cord in the yard of a desirable person will bless the baby with that person's characteristics [Indian]

   Other practices are:

   ...some mothers choose to bite off their baby's fingernails, rather than cut them, as it is believed that cutting them takes away the baby's strength
   ...some Southwestern Indians don't allow the baby to have his feet extended until the navel is healed, and grass or something soft is placed under the baby's knees until the navel is healed.

C. Abilities of the newborn

1. sucking
   (NOTE: Some mothers may be offended or frightened by their babies' early difficulties with sucking. They need reassurance, especially if their babies are small. Also, some babies need more sucking than others for a sense of security.)

2. hearing
   (NOTE: Babies respond with body movements to the rhythm and pitch of someone's voice.)

3. seeing
   (NOTE: Mothers may feel that their babies do not love them if they don't look at them. Stress that it is normal for babies to be very sleepy during the early days of life.)

4. smelling
   (NOTE: Babies who have early skin-to-skin contact with their parents learn to recognize them by their smell.)

5. touching
   (NOTE: Emphasize the importance of stroking as a means of stimulation of body processes as well as a mode of communication.)
6. crying
   (NOTE: Crying is the baby's mode of communicating his needs, as well as exercising his lungs and body muscles. Answering his needs promptly promotes a sense of well-being and does not spoil him during the first year.)

D. Early infant behavior
   1. differences in temperament often discernable at birth
   2. new babies awaken during the night to be fed and changed

E. Emotional needs
   1. acceptance and love of the child enhances his sense of self-worth
   2. tender, loving care is important to child's physical and emotional growth

F. Physical needs
   1. feeding
      (NOTE: Regardless of the choice of feeding method, the importance of mother-child contact should be emphasized, as well as the dangers related to propping a bottle. Acceptance of the individual's choice of feeding method is essential!)
   2. holding
   3. clothing
      (NOTE: Avoid emphasis on the purchase of layette items. Many young mothers cannot afford these things and may feel guilty. Encourage them to look at second-hand stores or accept offers of used clothing.)
   4. bathing
      (NOTE: The approach in the book is the medical one. However, technique has not been stressed to allow for cultural diversity.)
   5. health care
      (NOTE: Well-baby clinics are usually available at low-cost or free of charge. Check for available services in your area.)
   6. immunizations
   7. safety
      (NOTE: This is by no means a complete list. Explore this topic further with students.)

V. Suggested Methods
   A. Student activities: Have the student(s)
      1. list all of the things they think a mother should know before her baby is born

    a. check those they already know
    b. find out where they can learn about the ones they don't know

2. list some things that can be put in a baby's room to help his eyes and ears develop.
3. bring in toys from home and examine them for safety and appropriateness for age levels.
4. make a safe, colorful toy for a baby.
5. make a collage of the physical and emotional needs of infants.
6. listen to the record of babies' cries.
7. view films about newborns.
8. visit a nursery (day care center) to evaluate the care the children receive; i.e. feeding, playing, bathing, holding, sleep arrangements, etc.
9. relax and fantasize being helpless newborns, as described on p. 63. Discuss how it felt to need care and have to wait to get it. Discuss their change in feelings when their needs were met.
10. react verbally or in writing to the statement, "Newborn babies can't be spoiled!"
11. complete study guide.

B. Teacher activities: The teacher can
1. bring a newborn to class and discuss characteristics and abilities.
2. invite a public health nurse to discuss immunizations and well-baby care.

VI. Resource Materials

A. Films: The Newborn; How Babies Learn; Child Language Learning Without Teaching; The Amazing Newborn

B. Filmstrips/cassettes: Infant Care Series; Patient Teaching Series on Infant Care; Child Care and Development

C. Record - "Sounds of Babies"

D. Student reading: Infant Care (pamphlet); Babies Learn Through Play; The Phenomena of Early Development (pamphlet); What Every Child Needs (pamphlet)

E. Teacher reading: The Rights of Infants; The First Twelve Months of Life; The First Three Years of Life; 9 Months, 1 Day, 1 Year; Infants and Mothers

Chapter Fourteen

"Mama!" (Is That Me?)"

I. Objectives

A. To encourage the development of a happy and confident attitude toward parenting.

B. To encourage the young mother to develop an attitude of acceptance of herself and her child.

C. To help the young mother realistically understand and accept the responsibilities of parenthood.

D. To help the young mother be realistic about what she expects from her child.

E. To provide simple tools for coping with tensions and unexpected feelings.

II. Generalizations

A. The effectiveness of the parent is directly related to his/her self-concept.

B. Parenting behavior is influenced and often designed by cultural and societal standards and practices.

C. The way in which the individual was parented is reflected in his/her own parenting practices.

D. Learning constructive measures for the release of tension and anger can be helpful in reducing child abusive behaviors.

III. Student Objectives: The student will be able to

A. List and discuss four factors that can have a positive influence on one's effectiveness as a parent.

B. List four constructive methods by which one can release feelings of tension and/or anger.

C. Describe, from her own childhood experiences, the way in which she was parented, and how she perceives her own role as a parent.

D. List three factors to consider when choosing someone to care for an infant.

IV. Content

A. To become a good parent, it helps to
   1. feel good about oneself
   2. believe in oneself
   3. understand that parenting attitudes and practices are first learned from one's own parents

4. accept the responsibilities of parenthood
5. formulate realistic expectations of oneself and the child
6. learn constructive methods of coping with tension and anger

(NOTE: It is the authors' belief that the ability to parent effectively is influenced to a large extent by the individual's sense of self-worth. It has been our experience that the nurturance of a young mother herself helps her, in turn, nurture her own child. The importance of a supportive, caring relationship between the teacher [or care-giver] and the young parent cannot be overemphasized.)

B. Maternal instinct
(NOTE: Child abusive behavior sometimes results from emotional immaturity and feelings of inadequacy. Reinforcing the mother's natural protective instinct may help her cope with abusive persons in her environment [i.e. boyfriends, family members, etc.].)

C. Helpful hints for new parents
(NOTE: These are tools to assist the parent in coping with parental responsibility. Encourage students to explore this topic further and come up with other constructive methods for coping.)

D. Fathers
(NOTE: The role of the father has only been mentioned briefly, as many teenage mothers are without partners. However, we have found many young fathers to be responsive to help and encouragement in the assumption of parental responsibilities.)

E. Grandmothers
(NOTE: Many teenage mothers live at home and are dependent upon their own mothers for support and assistance. At times, this may result in conflict and confusion related to the maternal role. There may also be discrepancies between what she has learned at school and child-rearing practices at home. Sensitivity to this issue, as well as assistance in synthesizing the two is helpful for all concerned.)

F. Others
(NOTE: Students need assistance in assessing the adequacy of child-care givers.)

V. Suggested Methods

A. Student activities: Have the student(s)
1. make a list of 20 things they like about themselves (physical characteristics, personality traits, talents, etc.).
2. make a poster depicting the mother's responsibilities to her child.

3. do parenting priorities exercise (list in order of importance those qualities a parent should have). Share, in pairs, what each feels is most important. As a group, discuss the list. (NOTE: This is an excellent opportunity to bring out that differences in parenting practices exist and are O.K.!
4. explore own childhood and discuss how they would like to be like/different from their own parents. (NOTE: Students who have themselves been abused either physically or emotionally may be fearful of repeating that behavior with their own children. They may or may not approach you with this information. Encourage them to formulate alternative methods of coping and provide them with appropriate referral.)
5. role-play the handling of various situations related to child care (examples: crying baby at 2 a.m., baby pulling things off tables, potty-training, etc.). Discuss feelings and approaches.
6. role-play giving praise and positive criticism versus negative or destructive criticism.
7. report on what a child can be expected to learn at various ages and stages of development. (NOTE: Discuss variations in rate of development.)
8. discuss methods of releasing tension and/or anger. Decide which are constructive and which are destructive (to self or others).
9. view films/filmstrips on children and parenting.
10. visit a day care center or nursery to assess adequacy of care, costs, etc.
11. complete study guide.

B. Teacher activities: The teacher can
   1. read the IALAC story to student, showing how sense of self-worth is damaged by negative criticisms and interactions. Encourage positive interactions among students. Solicit examples and discuss.
   2. lead a discussion on the differences between discipline and punishment. Assist students in exploring the alternative methods of discipline and appropriateness for various ages.
   3. invite a social worker or counselor to speak on child abuse and the resources available.
   4. invite a counselor or psychologist to speak on the development of a positive self-concept.
   5. invite a speaker from a day-care center to talk about available facilities, types of care, costs, etc.

VI. Resource Materials

A. Films: Childhood, the Enchanted Years; Parenting Concerns: The First Two Years; Adapting to Parenthood; Day Care Today

B. Filmstrip/cassette: *Parenting: Fathers, Mothers, and Others; Parents' Magazine Series*

C. Student reading: Ross Laboratories pamphlet series on parenting; PMIC pamphlets on positive parent; *Parenting, A Guide for Young People; You*

D. Teacher reading: *I Am Loveable and Capable* (IALAC); *Between Parent and Child*

Chapter Fifteen

"Family Planning: Is It For YOU?"

I. Objectives

   A. To help explore various personal and cultural considerations as a basis for making decisions about family planning.

   B. To provide information about the various birth control methods, their use and availability.

   C. To dispel misinformation about conception and contraception.

II. Generalizations

   A. Personal values, knowledge, cultural beliefs, and peer and societal pressures influence decisions related to family planning.

   B. Knowledge of available methods of birth control is essential to the ability to plan and space pregnancies.

III. Student Objectives: The student will be able to

   A. Define family planning.

   B. List five things to consider when deciding whether or not to plan one's family.

   C. Name three methods of birth control which require a doctor's examination and prescription.

   D. Name two methods of birth control which can be used without a doctor's prescription.

   E. Name four unreliable methods of birth control.

   F. Explain how each of the following methods of birth control acts to prevent pregnancy: birth control pill, IUD, diaphragm, foam and condom.

   G. Explain exactly what a woman would need to do to use each of the above listed methods correctly.

   H. List two of the advantages and disadvantages of each of the above named methods of birth control.

   I. List four of the things which must be considered when choosing a method of birth control.

IV. Content

   A. Family planning defined

   B. Considerations related to family planning
      1. personal goals
      2. life situation

3. physical and emotional health (of both parents and children)
4. cultural beliefs and attitudes
5. religious beliefs

(NOTE: All of these will have an effect on an individual's decision of whether or not to space children. These lists have been offered as a basis for the student's developing personal awareness of her own preferences related to each topic.)

C. Conception reviewed
(NOTE: Make sure they've got this idea, as well as time of ovulation, before proceeding.)

D. Methods of birth control that "work best" and require a doctor's prescription.
(NOTE: We have tried to avoid using the term "most effective", as effectiveness is related to the individual's own choices and motivations.)

1. pill
   (NOTE: Some teenagers tend to go on and off the pill according to whether or not they have a boyfriend. Also, there are teens who will not use the pill because they are afraid their mothers will find out. Encourage discussion of these factors as they definitely influence their choices.)
2. I.U.D.
   (NOTE: One of the "advantages" refers to the fact that no one but the woman herself needs to be aware of the presence of the I.U.D. Cases in which the woman desires to contracept and her parents object, can be discussed. Also, we realize there are different theories as to how the I.U.D. prevents pregnancy. However, since they are not considered conclusive, we have chosen to omit them.)
3. diaphragm
   (NOTE: There is some evidence to indicate that the diaphragm does not cover the cervix during orgasm. There are many implications related to this. Perhaps the most significant is that the use of contraceptive cream or jelly is essential to block the cervix and kill the sperm during orgasm.)

E. Methods that can be obtained without a doctor's prescription

1. condom
   (NOTE: Many teenage girls are reluctant to ask their partners to share in the responsibility for contraception. Often this comes out during the discussion of the condom.)

2. foam
(NOTE: Stress that running to the telephone or waiting too long after putting in foam can greatly decrease its effectiveness! Remind students that this is the method doctors often recommend during the four to six weeks following delivery, or if they are breastfeeding for a short period of time, and that it is most effective when used with the condom.)

F. Natural family planning methods
(NOTE: Stress that the effective use of these methods depends upon how well-trained the woman is and how motivated she is to do what is required of her. She needs to consult a family planning counselor or doctor for complete information.)

G. Methods that don't work
(NOTE: These are the most common contributions from our students. There are probably many more misconceptions. Have your students share all they've heard of.)

H. Things to consider when selecting a method
(NOTE: Spend time discussing these. The answers make a great deal of difference!)

V. Suggested Methods

A. Student activities: Have the student(s)
1. view films and filmstrips on family planning and birth control.
2. bring in articles from newspapers or magazines related to birth control.
3. talk to clergymen and report on religious attitudes about contraception. Share in class.
4. debate on the topic of whether or not people "should" plan their families.
5. view films on population and environmental issues.
6. report on the history of birth control.
7. go to a drugstore and report on available methods of contraception, costs, etc.

B. Teacher activities: The teacher can
1. display the various methods, using a plastic pelvic model for demonstration of use.
2. plan a field-trip to a family planning clinic.
3. take a poll of the class as to how many children each wants. Discuss differences in values and reasons for preferences.
4. invite a doctor or family planning counselor to talk about birth control methods.
5. make a birth control card game. (Make a separate card for the name of each method, how it is used, how it works, advantages, disadvantages.) Cards are shuffled. Student must match the name of the method with the cards that apply to it. This may be done in groups or individually.

(NOTE: Teaching family planning can be very enjoyable for both teacher and students. A relaxed, accepting atmosphere is essential. Be prepared! Students will surely ask you very personal questions related to your own sexual activity, values related to family planning, and favorite method. Your non-verbal responses will give you away and may have more influence on their choices than you might think. It is best to decide ahead of time how you will respond to their questions, as well as attempt to become aware of your own biases. Remember that family planning is not an acceptable choice for everyone.)

VI. Resource Materials

A. Films: To Plan Your Family; Happy Family Planning; Hope Is Not A Method; Tomorrow's Children

B. Student reading: Birth Control, All the Methods That Work and the Ones That Don't; (pamphlet); Basics of Birth Control (pamphlet); The Advantages of Family Planning (pamphlet); What's Happening (pamphlet); Decisions About Sex; Facts About Sex for Today's Youth

C. Teacher reading: Sex Is Never An Emergency; Sex and Birth Control: A Guide for the Young; Margaret Sanger: Pioneer of Birth Control

D. Birth control demonstration kit and pelvic model, Ortho Pharmaceutical Company

TEENAGE PREGNANCY: A NEW BEGINNING

Teacher's Diary

Date(s)______________________________

Chapter of Book________________________

1. Student Book
   - a. completeness of information
   - b. information missing
   - c. illustration and/or photography
   - d. reading level
   - e. appropriateness of information, photos and illustrations
2. Teachers Manual
   - a. usefulness of objectives

     Suggested additions, changes, deletions:
   - b. usefulness of concepts

     Suggested additions, changes, deletions:

c. usefulness of Student Objectives

Suggested additions, changes, deletions:

d. usefulness of Content Outline

Suggested additions, changes, deletions:

e. usefulness of Suggested Methods

Suggested additions, changes, deletions:

f. usefulness of Suggested Resources

Suggested additions, changes, deletions:

Resources used:

Difficulties in obtaining resources:

How did you resolve these difficulties:

g. Student response to chapter:

STUDENT STUDY GUIDE

for

TEENAGE PREGNANCY: A NEW BEGINNING

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(1)

"Teenagers Talk About Their Pregnancies"

NAME: READ: Chapter 1, pp. 5-7

DATE:

Finish each sentence by writing your own ideas and feelings.

1. "When I first found out I was pregnant, I..........."

2. "Now that I'm pregnant, I feel........."

3. "The hardest decision I've had to make about pregnancy is......"

4. "When people give me advice, I........."

5. "When I look at my body, I see........."

6. "I am worried about..........."

7. Fill in the following chart with your ideas about what other people want from you.

"What people want me to be like"

PARENTS	BROTHER/SISTERS	FRIENDS
NEIGHBORS	TEACHERS	ME

8. Underline all the things you agree with on the above chart. Cross off those things you don't agree with.

(3)

"UNDERSTANDING HUMAN REPRODUCTION"

NAME: READ: Chapter 2, pp. 8-12

DATE:

1. Draw a picture of the woman's reproductive organs and label each part.

2. Explain the function of each of the following:

   a) ovary

   b) fallopian tube

   c) uterus

   d) cervix

   e) vagina

   f) ovum

3. Explain what menstruation is.

4. What is ovulation?

5. When do you ovulate?

6. What is fertilization?

7. During what time of the month can a woman get pregnant?

8. Draw a picture of the man's reproductive organs and label each part.

9. Explain the function of each of the following:

a) penis

b) testicles

c) scrotum

d) vas deferens

e) seminal

f) urethra

g) bladder

h) sperm

i) semen

10. What is nocturnal emission? Is this normal?

11. What is an erection? What causes an erection?

12. How many sperm are ejaculated each time a man "comes"?

13. How many sperm does it take to fertilize an egg?

14. How would you answer this letter?

"Dear Abby:

My mother says it's wrong to have sex before marriage. Some of my friends are doing it, and my boyfriend wants to. What should I do?

"Two Stories At Once"

NAME: READ: Chapter 3, pp. 13-20

DATE:

1. Why are the first three months of pregnancy so important to the developing baby?

2. What is the placenta? What does it do?

3. What does the bag of water do for the unborn baby?

4. Describe what the unborn baby looks like and what he can do at:

    a) 3 months (12 weeks)

    b) 4 months

    c) 6 months

    d) 7 months

    e) 9 months

5. There are many signs that may appear when you are first pregnant. List as many of these as you can.

6. What are the changes in the mother's body during the:
   a) first trimester
   b) second trimester
   c) third trimester

7. How do the pregnant woman's emotions change during each trimester?
   a) first trimester
   b) second trimester
   c) third trimester

8. Define

a) fertilization

b) implantation

c) embryo

d) fetus

e) umbilical cord

f) placenta

g) amniotic sac

h) amniotic fluid

i) colostrum

j) quickening

k) lanugo

l) vernix

m) engagement

"Your Health Care During Pregnancy"

READ: Chapter 4, pp. 21-23

NAME:

DATE:

1. Why is it important for a woman to see a doctor early and regularly during her pregnancy?

2. List four blood tests that will be done on your first visit to the doctor.
   1)
   2)
   3)
   4)

3. How much weight should you probably gain during pregnancy?

4. What are the dangers of not gaining enough weight?

5. List four reasons why a pelvic exam will be done on your first visit to the doctor.
   1)
   2)
   3)
   4)

(10)

"Keeping Yourself Well During Pregnancy"

NAME: READ: Chapter 5, pp. 24-30

DATE:

1. What advice would you give a pregnant woman about each of the following:

   a) rest

   b) bathing

   c) clothing

   d) breasts

   e) teeth

   f) housework

   g) travel

   h) sexual relations

   i) exercise and sports

   j) douching

2. Many of the things that bother a pregnant woman (common complaints) can be helped by changes in how she eats. Name four things and tell what changes she should make..

   1)

   2)

   3)

   4)

3. Other complaints can be helped by prenatal exercises and good posture. Name three and tell what exercises will help.

   1)

   2)

   3)

4. Of all the common complaints, which ones have bothered you the most? What have you found that has helped?

(12)

"Be Good to the Baby Before He's Born"

NAME: READ: Chapter 6, pp. 31-33

DATE:

1. List six things that are dangerous to the unborn child and tell how each might hurt him.

   1)

   2)

   3)

   4)

   5)

   6)

2. What is venereal disease? How do you get it?

   a) How does syphilis affect the unborn baby?

   b) How does gonorrhea affect the baby?

3. What are you doing to have a healthy baby?

4. What other things have you heard of that might hurt the unborn baby?

5. List nine danger signs of pregnancy which should be reported to the doctor.

1)

2)

3)

4)

5)

6)

7)

8)

9)

"Eating For Two"

NAME: READ: Chapter 7, pp. 34-39

DATE:

1. Why is it especially important for a pregnant teenager to eat well?

2. List four ways that eating well during pregnancy helps the mother.
   1)
   2)
   3)
   4)

3. List four ways that it helps the baby.
   1)
   2)
   3)
   4)

4. Fill in the following chart.

NUTRIENTS	WHAT DOES IT DO?	WHAT FOODS CAN YOU GET IT FROM?
Protein		
B Vitamins		
Vitamin A		
Vitamin C		
Vitamin D		
Calcium		
Iron		
Folic Acid		

5. Keep a record of everything you eat for one full day.

Breakfast:

Snacks:

Lunch:

Snacks:

Dinner:

Snacks:

6. Decide which food group each food you ate belongs in. Count up the total number of servings in each group.

Fill in the following chart:

	How Many I Had	How Many I Need	What I Could Add To Make It Complete
Milk & Milk Products			
Meat & Other Products			
Fruit & Vegetables			
Bread & Cereals			
Water & Other Fluids			

7. Plan a day's meals for a pregnant teenager. Be sure she gets everything she needs. Use only foods you like to eat!

Breakfast:

Snacks:

Lunch:

Snacks:

Dinner:

Snacks:

"Deciding What's Best For You And The Baby"

NAME:

READ: Chapter 8, pp.40-52

DATE:

1. Mary is 16 years old and pregnant. She is in the 11th grade and lives at home with her parents. Her parents want her to release her baby for adoption. Her boyfriend is also 16. He wants to run away and get married. Mary doesn't know what she wants to do. List the advantages and disadvantages of keeping her baby, releasing it for adoption, and getting married.

2. When you are trying to solve a problem, it helps to use the steps in making a decision (page 45). Choose a problem that you would like to solve and answer the following questions:

   a) What is the problem?

   b) What kind of information do you have or need to solve this problem? Where can you get the information you need?

c) Fill in the following information:

My choices are:	Things I like	Things I don't like

d) Which choice seems to fit you best? Why?

e) Can you be happy with this choice?

"What To Expect In The Hospital"

NAME: READ: Chapter 9, pp. 53-59

DATE:

1. When do you go to the hospital in labor?

   Where do you go?

   What should you take?

2. What is a "prep"? Why is it done?

3. What is an enema? Why is it done?

4. Why shouldn't you eat a large meal when you are in labor?

5. How does the doctor make sure you get enough fluids?

6. What is the episiotomy? Why is it done?

7. What kind of care does the new baby get in the delivery room?

8. What will the nurses do for you during the first hour after delivery?

Why will they massage (rub) your uterus?

9. What is a sitz bath? Why should they be taken each day?

10. If a mother is planning to keep her baby, why is it important for her to spend time with the baby during the hospital stay?

11. Define:

a) forceps

b) circumcision

"Being Comfortable During Labor"

NAME: READ: Chapter 10, pp. 60-63

DATE:

1. In your own words, explain what "natural childbirth" means.

2. Name three reasons why it is important to be prepared for childbirth.

    1)

    2)

    3)

3. What is a labor "coach"?

    What can the "coach" do to help the mother during labor and delivery?

4. What is analgesia?

Why is it used during labor?

5. What is anesthesia?

Why is it used during labor and delivery?

6. Describe the area of the body which is numbed by each of these types of anesthesia. Tell when each can be given.

   a) Saddle Block or Spinal

   b) Caudal or Epidural

   c) Paracervical

   d) Pudendal

   e) Local

7. Why is gas anesthesia not usually used for normal childbirth?

8. Which type of anesthesia would you rather have?

(24)

"Labor and Delivery"

NAME: READ:Chapter 11, pp. 64-69

DATE:

1. List three signs that labor is beginning:

   1)

   2)

   3)

2. List the differences between true and false labor:

TRUE LABOR	FALSE LABOR

3. List the first three stages of labor. Explain what happens during each stage and what the woman can do to help herself during each one.

   1)

2)

3)

4. What happens during the "fourth stage of labor"?

5. Tell what the mother may feel during the transition phase of labor.

6. Define:

   a) contraction

   b) crowning

   c) dilation

   d) effacement

7. Is there anything about labor that scares you? If so, what?

8. What is a Cesarean Section?

"After the Baby's Born....Now What?"

NAME: READ: Chapter 12, pp. 70-73

DATE:

1. The first six weeks after delivery are called the postpartum. Name at least four changes that will happen to the mother's body during this time.

   1)

   2)

   3)

   4)

2. Name at least five things a new mother can do to help her body return to normal after childbirth.

   1)

   2)

   3)

   4)

   5)

3. After delivery, a woman has a bloody discharge called lochia for about four to six weeks. Explain why.

4. Many women get the "baby blues" soon after delivery. Why does this happen?

Name three things she can do to help herself with the "blues".

1)

2)

3)

5. How is a woman's care different if she has had a cesarean birth?

6. What is the purpose of the postpartum check-up?

7. Define:

a) engorgement

b) "afterpains"

c) Involution

"Hello Stranger"

Name: Read: Chapter 13, pp. 74-80

Date:

1. Describe the following things about a newborn.

   a) head

   b) eyes

   c) nose

   d) "soft spot"

   e) chin and neck

   f) body

   g) skin

   h) hair

   i) cord

2. List six things a baby can do as soon as he's born.

   1)

   2)

   3)

   4)

   5)

   6)

3. Why is tender, loving care important to an infant?

List five ways you can give a baby tender, loving care.

1)

2)

3)

4)

5)

What happens to a baby who does not get his needs met?

4. Why is it important to hold a small baby when you feed him?

   a)

   b)

5. What advice would you give a new mother about clothing for her baby?

   a)

   b)

6. What are three important things to remember when giving a baby a bath?

   1)

   2)

   3)

7. What are two important things to remember about your baby's health care?

   1)

   2)

8. The DPT shot protects your baby from which three diseases?

   1)

   2)

   3)

9. The MMR shot Protects your baby from which diseases?

   1)

   2)

   3)

10. How is the polio immunization given to a baby?

11. List six important safety rules to make sure a baby is safe and tell why each is important.

    1)

    2)

    3)

    4)

5)

6)

12. There are many other safety rules that aren't in the book. Think of three.

1)

2)

3)

13. Sucking is important to a baby to be able to get food. Give another reason why it is also important.

How do you feel about letting a baby suck on a pacifier?

14. Give three reasons why babies cry.

1)

2)

3)

Why is it important to go to your baby when he cries?

NAME: READ: Chapter 14, pp. 81-94

DATE:

1. How can feeling good about yourself help you become a good parent?

2. Describe the kind of parent you want to be.

3. What are the responsibilities of being a parent?

4. What happens if you try to teach a child something before he is ready to learn it?

5. What are some helpful things you can do when.........

   a) you are tense (list three)

b) you are angry (list three)

6. Think back on your own childhood and how you were treated.

   a) List three ways you want to be like your own parents.

   b) List three ways you want to be different when raising your own child.

7. What advice would you give a new parent? Name three helpful hints.

   1)

   2)

   3)

8. List three things to look for when you choose someone to take care of your baby.

   1)

   2)

   3)

"Family Planning: Is It For You?"

NAME:

READ: Chapter 15, pp. 85-91

DATE:

1. What is family planning?

2. List five things to think about when deciding whether or not to plan your family.

   1)

   2)

   3)

   4)

   5)

3. Which methods of birth control do you have to see a doctor for?

   a)

   b)

   c)

4. Which methods of birth control can you use without a doctor's prescription?

   a)

   b)

5. List six things that will not keep you from getting pregnant.

1)

2)

3)

4)

5)

6)

6. List four things you will need to think about when deciding which method would be right for you.

1)

2)

3)

4)

7. Complete the chart on the following page.

METHOD OF BIRTH CONTROL	HOW DOES IT WORK?	WHAT DO YOU HAVE TO DO TO USE IT CORRECTLY?	ADVANTAGES	DISADVANTAGES
PILLS				
I.U.D.				
DIAPHRAGM				
FOAM				
CONDOM				

"For The Father Of The Baby"

NAME:

READ:Chapter 16, pp. 92-93

DATE:

1. What do you think are some of the problems that young fathers have? Discuss three.

   1)

   2)

   3)

2. Do you think there is information in this book that would be helpful for young fathers? Why or why not?

3. What do you think a man needs to know to be a father?

"Breastfeeding"

Read: "Breastfeeding, Something Special for Mother and Baby"

1. Name 3 health benefits of breast feeding to the mother.

2. Name 5 health benefits of breastfeeding to the baby.

3. Compare the advantages of breastfeeding and bottle feeding.

ADVANTAGES OF BREASTFEEDING	ADVANTAGES OF BOTTLE FEEDING

4. What should any pregnant woman do to care for her breasts during pregnancy?

5. Name at least 3 preparation exercises which should be practiced by the woman who plans to breastfeed.

List 3 reasons why preparation is important.

6. What is the function of each of these parts of the breast:

Milk glands(alveoli)

Mild ducts

collecting sinuses

7. What is engorgement? List the things which a woman can do to prevent engorgement:

8. List the things a woman can do to treat engorgement.

9. List the things which should be done to prevent sore nipples.

10. List the things which can be done to treat sore nipples.

11. List 4 stories about breastfeeding which are not true

12. Some women should not breastfeed. Name 3 times when this is true.

DATE____________________ LOCATION____________________

YOUR GRADE IN SCHOOL________ YOUR AGE________

Student Survey Checklist

A. Teenage Pregnancy: A New Beginning

1. Do you like the way the book looks:

   a. very much

   b. some

   c. not at all

   What would make it look better?____________________

   ____

2. Did you like the pictures:

   a. very much

   b. they were OK

   c. didn't like them

   What kind of pictures would be better? ________________

   ____

   Were there other pictures that should be in the book, but are not there? ____________________

   ____

3. Were the drawings:

   a. very helpful

   b. helpful

   c. not helpful

4. Were the drawings:

a. very easy to understand

b. fairly easy to understand

c. hard to understand

d. very hard to understand

What would make the drawings easier to understand?________

____

5. Did any of the drawings "turn you off":

a. yes

Which ones?______________________________

b. they were OK

c. No

6. Was the book:

a. too easy to read

b. fairly easy to read

c. about right

d. hard to read

e. too hard to read

7. If you found the book hard to read, was it because:

a. the words were too big

b. the sentences were too long

c. didn't make sense to me

d. other reasons______________________________

____

____

8. Were the topics in the book covered:

   a. too much

   b. about right

   c. not enough

   What should be added or made longer to make the book more complete?______________________________________

   ____

   What do you think should be left out or made shorter?____

   ____

   ____

9. Who do you think would get a lot out of reading this book:

   a. teen who is not pregnant

   b. teen who is pregnant

   c. parents of pregnant teens

   d. parents of any teenager

   e. school nurse

   f. school counselor

   g. my boyfriend

   h. other____

   ____

10. How did this book make you feel:

    a. more worried about my pregnancy

    b. no different than before

    c. more able to handle my pregnancy

11. Do you have other ideas of how to make the book prettier, better, easier to read, or more useful? Please list them here: ____

____

____

B. Student Study Guide for Teenage Pregnancy: A New Beginning

12. Were the study guide sheets:

a. very useful

b. useful

c. not useful

How could the study guide sheets be more useful? __________

____

13. Did you use and fill out:

a. all study guide sheets

b. some study guide sheets

c. no study guide sheets

14. Was filling out the study guide sheets ?

a. very hard

b. a little bit hard

c. easy

d. very easy

If it was hard to fill out the study guide sheets, what changes would make them easier? ______________________________

____

____

THANK YOU!

Breastfeeding
Something Special for Mother & Baby

for use with

TEENAGE PREGNANCY: A NEW BEGINNING

by Toni Berg, B.S.N.

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BREAST FEEDING

Something Special for Mother and Baby

This booklet is about breast feeding. One of the things which most of you will do while you are pregnant is to decide how you will feed your baby. One of the ways that you may choose is breast feeding. Even if you have decided not to keep this baby, you will probably have another baby sometime in your life. If you do, you will make the choice of breast or bottle feeding then.

Most people know about bottle feeding, but not very many people know much about breast feeding any more. That seems strange since babies have been breast fed for thousands of years. One reason for giving you this booklet is so that you can learn about breast feeding, and then you will be able to decide which feeding method would be best for your baby and you. This booklet is yours to keep and read as many times as you would like to. If you would like to read more about breast feeding, there is a small list of other good books at the end of this booklet.

WHY BREAST FEED?

There are many reasons why you should think about breast feeding your baby. First, breast feeding is healthier for both mother and baby.

HEALTH REASONS FOR BREAST FEEDING

Breast feeding is good for mothers because:

..... it is easier for the mother to lose the weight she gained during pregnancy and she gets her figure back sooner

..... the mother's uterus gets back to its normal size and position sooner

..... breast feeding cuts down the amount of blood lost after delivery

..... breast feeding may help prevent breast cancer

..... breast feeding gives the mother a chance to sit down and rest while she feeds the baby

Breast feeding is especially good for babies because:

..... human milk is the perfect food for human babies

..... human milk is easier to digest than formula

..... breast fed babies do not usually have trouble with colic

..... breast fed babies do not usually have trouble with constipation

..... breast fed babies do not usually have trouble with diarrhea

..... breast fed babies do not spit up as much as bottle fed babies

..... breast milk protects the baby from many diseases in the first months of life

..... breast fed babies have less trouble with colds and other infections

..... breast fed babies do not have as much trouble with allergies, especially food allergies

..... breast fed babies usually don't get too fat

..... breast feeding helps the baby's jaws and teeth to develop right

..... breast fed babies have less trouble later with tooth decay

..... breast fed babies are always held close for feedings

These are only some of the health reasons for breast feeding. We are finding out more things all the time that show us that breast feeding is very good for mothers and babies.

There are other reasons for breast feeding, too. Breast feeding is easier for most mothers.

Breast feeding is easier because:

..... breast milk is always ready -- you don't have to spend time making formula and washing bottles

..... the milk is always warm -- you don't need to warm up bottles

..... breast feeding saves money -- you can use the money you save to buy other things - you don't have to spend money on bottles and formula

..... you don't need other foods for the baby for several months -- breast milk is all he needs

..... it is easier to feed the baby at night -- you don't have to listen to the baby cry while you warm up the bottle

..... it is easier to go some place -- no need to carry bottles and worry about bad milk or different water

Can any mother breast feed?

Yes. Almost every mother can breast feed if she wants to. The mother's body was made to breast feed. It doesn't matter what size your breasts are. They can make plenty of milk for a baby. (Some mothers even breast feed twins!)

There are a few women who should not breast feed. For example, mothers who take drugs, like heroin or speed, should not breast feed. But most healthy normal mothers can breast feed, and the ones who do say it is wonderful.

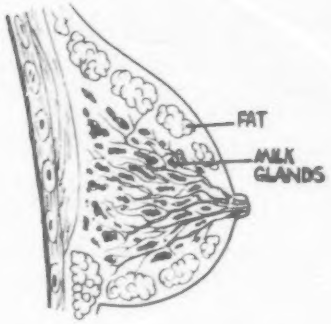
How long can a mother breast feed?

For as long as she and her baby want to. It is really good if a baby can be breast fed for the first year. Some mothers nurse longer and some not as long. We would encourage you to breast feed as long as you can. Breast fed babies really don't need to start solid foods until they are 4 to 6 months old, so you don't need to worry about that for a while. Many mothers breast feed even though they are working or going to school. It is a matter of working out your time.

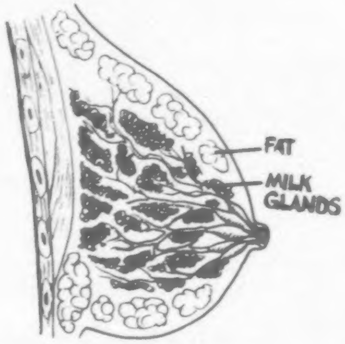
Even if a mother can only breast feed for a few weeks, that is still very good for her and her baby. The few weeks that the mother breast feeds help her and give her baby a head start in life.

HOW DOES BREAST FEEDING WORK?

WHAT THE BREAST LOOKS LIKE INSIDE



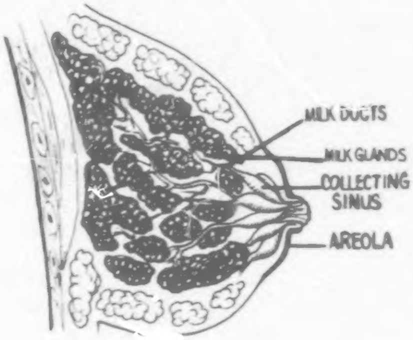
Before Pregnancy



During Pregnancy

Before you became pregnant, your breasts had mostly fat inside them. The amount of fat tissue you have in your breasts is what decides how large your breasts are. Before pregnancy, you have very small areas of milk glands. They do not grow until you become pregnant.

When you first become pregnant, your breasts start to get ready for making milk. The breasts start to grow larger as the milk glands start to get bigger.



THE BREAST AT THE END OF PREGNANCY

In this picture of the breast, you can see the parts of the breast that are important in breast feeding. The milk is made in the milk glands, those little groups of sacs inside the breast. The milk is carried from the milk glands by the *milk ducts*, down to the *collecting sinuses*. These collecting sinuses are little pools where some of the milk is stored. The collecting sinuses are found just under the *areola*, that dark area of skin around the nipple.

About the 5th month of pregnancy, the milk glands start to make a fluid called *colostrum*. This is the first fluid made by the breasts as they get ready to make true milk after the baby is born. Colostrum may look clear, milky or yellow. All those colors are normal. If you decide to breast feed your baby, colostrum will be the baby's first food after delivery. (The "true" milk starts to come in on the second or third day after delivery.) You may find that the colostrum comes out of the nipple in little drops once in a while during pregnancy.

When the baby is born and the placenta is delivered, the mother's body tells the breasts to start making "true" milk. The colostrum that the baby gets those first two or three days is very good for him: it has lots of protein and *immunities* that keep the baby from getting sick. If you are going to breast feed your baby, *it is very important that he be breast fed during those first days so that he gets the colostrum and so that the breasts know to keep making milk*.

Breast feeding works on a *supply and demand* system. That means that the breasts will make as much milk as the baby takes. The more milk the baby needs, the more milk the breasts will make. In order to have plenty of milk for your baby, you need to nurse the baby *on demand*, when the baby is hungry, starting as soon after delivery as possible. The more the baby nurses, the more milk the breasts will make. This is how breast feeding mothers keep up with the needs of their babies as the babies get bigger and older.

Another thing that is very important in breast feeding the baby is the *let-down reflex*. When the baby takes the nipple in his mouth and starts to nurse, this sends a message to the mother's brain and then to the breasts to let the milk flow. This takes about a minute after the baby starts to nurse. Then the mother will usually feel a very heavy, tingling feeling in the breasts, and milk will start to drip from both breasts. For some women, just touching the nipple by accident, or hearing a baby cry, will cause the let-down reflex to work. (If you start to leak milk at a bad time, just press your hands against your nipples and it will stop.)

GETTING READY TO BREASTFEED: HOW TO PREPARE

There are some things that you can do during pregnancy to get ready for breast feeding. These things are called preparation exercises. It is a good idea to practice these things even if you are not quite sure that you are going to breast feed. Then, if you do breast feed, you will be ready.

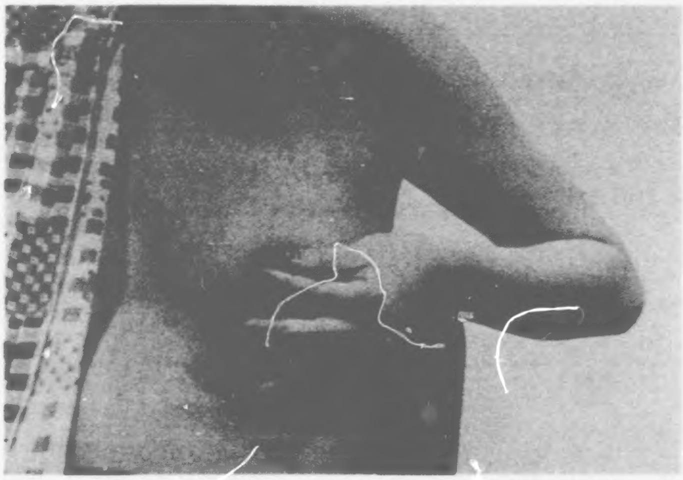
You should start doing the preparation exercises about 8 weeks before your baby is due. The exercises you need to learn are:

1. Nipple rolling or nipple conditioning
2. Breast massage
3. Removing the milk by hand (called manual or hand expression)

Doing these exercises can help you in many ways with breast feeding. The following pictures will show you what to do for each exercise. Under each picture is an explanation of why the exercise is important, and how to do it.

1. Nipple rolling or nipple conditioning

Nipple rolling and nipple conditioning will help the nipples to stick out so that the baby will be able to get the nipple in his mouth to nurse. Many women have "flat" nipples which do not stick out very much. These women should be sure to learn nipple rolling. Some people think that nipple rolling will help make the nipple skin stronger.



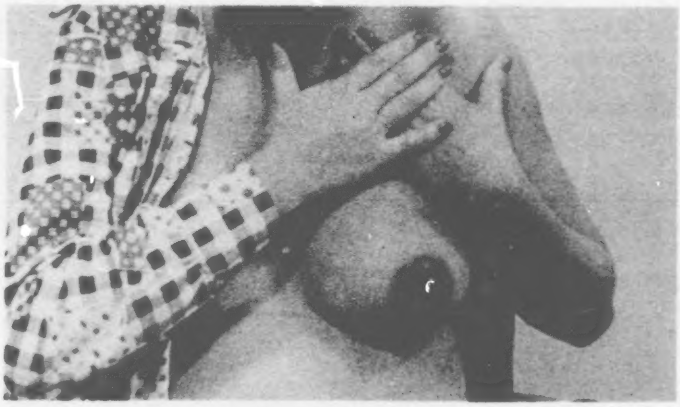
TO DO NIPPLE ROLLING: Support the breast with one hand underneath it. With the other hand, hold the nipple at the base, between your thumb and first finger. Now roll the nipple gently along your finger while you very gently pull out on the nipple. Do the same thing with the other nipple. Nipple rolling should be done at least once each day for the last 6 to 8 weeks of pregnancy.

2. Breast massage

Breast massage helps the blood to flow more through the breasts, and helps to stretch the walls of the milk glands so that they can hold more milk. Breast massage also helps to keep you from getting engorged when the "true" milk comes in. Engorgement is a very uncomfortable over-fullness of the breasts.

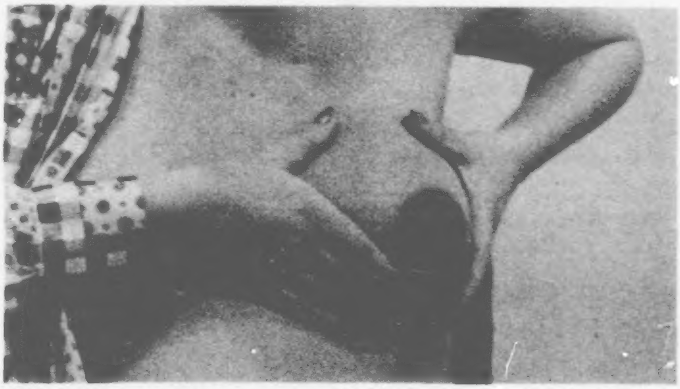
TO DO BREAST MASSAGE:

Step I.



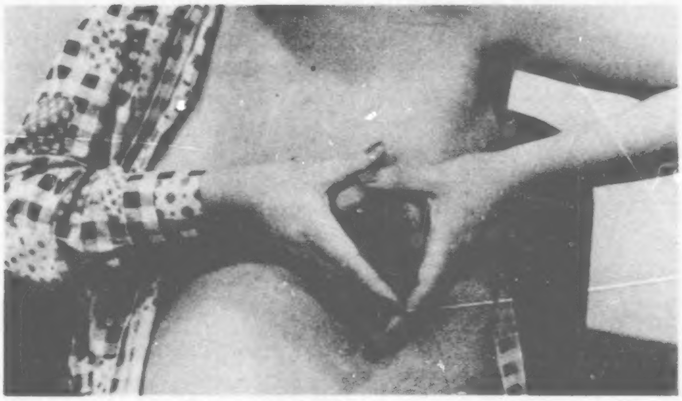
Start the massage with your hands crossed over the top of the breast as shown here.

Step II.



Move your hands down along the sides of the breast, with your thumbs on top and your fingers around the sides and bottom of breast.

Step III.

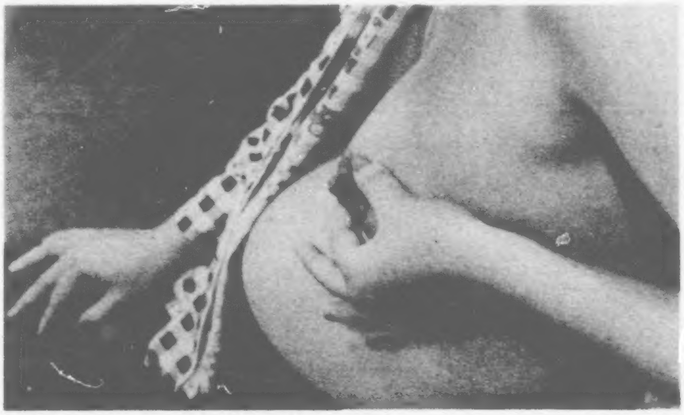


Your hands should cup the breast now and lift it a little from the bottom. Move your hands out, over the end of the breast, but don't massage the nipple or areola.

Breast massage should be done 8 to 10 times on each breast once a day, starting 6 to 8 weeks before the baby is due.

3. Removing the milk by hand

Removing the milk by hand, or manual expression, is important because it helps you to have more colostrum, and it helps you to keep from getting engorged when the "true" milk comes in. If you have more colostrum, that means the baby will get more of it the first two days, and you may also find that your "true" milk comes in sooner.



TO DO THE MANUAL EXPRESSION: Support the breast with one hand under it. Place the thumb and first finger of your other hand at the edge of the areola (the dark area around the nipple). Pull the skin back tight over the breast and then gently squeeze down toward the nipple. Move your thumb and finger to the other side of the nipple and do this again. This takes practice, so don't get upset if you don't get any colostrum the first time you try. Just keep practicing and you will get the hang of it. Wipe away the colostrum with a clean wash cloth or cotton ball. Manual expression should be done once each day on each breast for the last 6 to 8 weeks before the baby is due.

Take Good Care of Your Breasts

Even if you decide not to breast feed your baby, you should still take good care of your breasts. Here are some things that all pregnant women should do:

1. Wear a good fitting bra that supports your breasts. Breast feeding does not cause your breasts to "sag", but going without a bra while you are pregnant can cause your breasts to sag.
2. Wear a clean bra every day.
3. Wash your breasts every day with plain, warm water. DO NOT USE SOAP ON YOUR NIPPLES. Soap dries out the skin and can cause cracked nipples.
4. Always wash your hands before you handle your breasts.

Take Good Care of Yourself

It is very important for a breast feeding mother to take care of herself so that she will be healthy and have enough milk for her baby. Here are some things you should do:

1. Be sure to eat regular meals, using the same food guide that is given for pregnancy. If you don't eat well, you won't feel very good, and your milk may not keep up with your baby.

2. Be sure to drink enough fluids -- 12 to 16 glasses each day -- of water, milk, fruit juices, etc. (Not more than two cups each day of coffee, tea and soft drinks.)

3. Get enough rest. This is very important since being too tired may keep the let-down reflex from working right. You should rest some while the baby sleeps during the day. That will help make up for the sleep you might lose when you get up to feed the baby at night. Day feeding times are good times to relax and rest, too.

4. Don't feel guilty if you let other things go for a while. It is more important for you to be relaxed and rested than it is to do the dishes. If you get really tense or up-tight, that can keep the let-down reflex from working right, too.

BREAST FEEDING THE NEW BABY

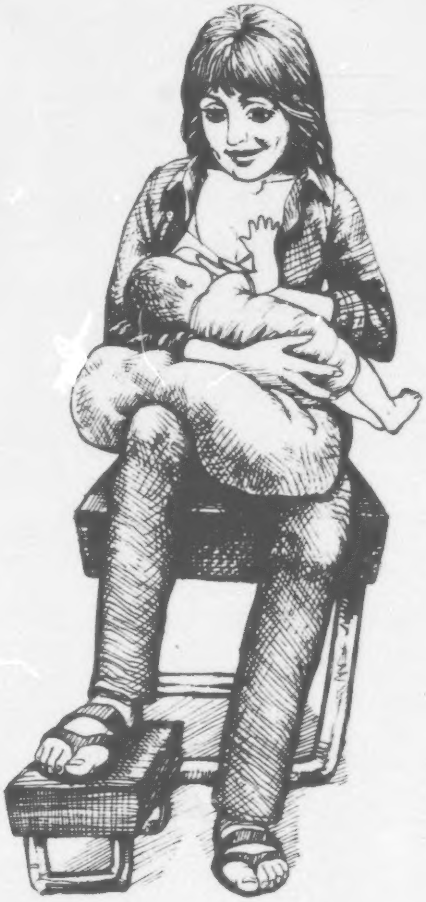
A. GETTING STARTED

After the baby is born, it is important to start nursing as soon as possible. Many hospitals now let mothers breast feed their babies in the delivery room, or during the first hour after birth. If you can do that, by all means, do! It really helps to be able to start that soon. If you can't start nursing the first hour after delivery, start as soon as you can. Talk to your doctor about keeping the baby with you as much as possible, or at least nursing the baby on demand.

The first few feedings may not be easy for you or the baby. Remember, you both have to get acquainted and learn about nursing. Take your time and don't get upset if the baby doesn't nurse well at first. It takes time and a little practice.

Here are a few tips to help you get started:

1. Always wash your hands before handling your baby or your breasts.
2. Before you nurse the baby, it may help you to massage the breast, roll the nipple so that it will stand out, and then express some colostrum.
3. Get comfortable. Most mothers find it best to start nursing while sitting in a chair. Sit on a pillow if you have sore stitches. It helps also if you can cross your leg or put your foot on a foot stool.



4. Hold the baby with his head cradled in the crook of your arm and his face close to the breast. It helps to put a pillow on your lap to rest the baby on and raise his body to the right height.

5. Brush the baby's cheek with your nipple or your finger. The baby will turn to your touch and open his mouth. This is called "rooting"; the baby is born with the rooting reflex. (NOTE: Do not try to push the baby to the nipple; he will turn against your hand.)

6. When the baby opens his mouth and takes the nipple, be sure that he has the areola in his mouth, too. If he just chews on the nipple, he won't get any food and will make you sore.

7. Nurse the baby about 5 minutes at each breast each feeding the first day. Slowly, add to the time you nurse at each feeding the days after that. By the 4th day, you should be nursing about 15 minutes at the first breast and 10-15 minutes at the second breast.

8. Always break the suction before moving the baby away from the nipple. You can break the suction by putting your clean finger against the breast at the corner of the baby's mouth and pressing down against the breast.

9. Burp or bubble the baby after he has nursed at the first breast, and at the end of the feeding. The baby may not burp very much since breast fed babies don't usually get much air into their stomachs.

10. The most important thing to remember as you start to nurse your baby is to RELAX. As you and your baby learn about each other, you will come to enjoy the feedings more and more.

PROBLEMS

Some women have trouble with engorgement and sore nipples when they are breast feeding. Here are some things which can help keep you from getting into these problems, and ways to help them if you do get them:

1. Engorgement - uncomfortable overfullness of the breasts.
   To keep from getting engorged, you should:
   a. Learn and practice the breast massage and manual expression of colostrum before delivery.
   b. When baby is born, begin nursing as soon after delivery as possible.

c. Nurse the baby on demand and don't skip feedings.

d. Be sure baby nurses long enough (about 10 minutes) to empty the breasts.

To get rid of engorgement:

a. Stand under a warm shower, or make a hot pack for your breasts by soaking a bath towel in hot water and then wrapping it around yourself for about 10 minutes. Heat helps the milk to flow.

b. While you are in the shower or after using the hot pack, massage the breasts to move the milk down out of the clogged milk glands. If you are very badly engorged, you may find that this hurts a little until you have gotten some of the milk out.

c. After massaging, express some of the milk -- just enough to make the nipple and areola soft and make yourself comfortable.

d. Put the baby to the breast so that he can finish emptying out the milk.

e. To keep from getting engorged again, be sure to nurse the baby on demand and DON'T SKIP FEEDINGS.

Engorgement is one of those things that shouldn't happen, but when it does, it must be taken care of right away. Engorgement flattens out the nipple so the baby can't nurse right. As he chews on the nipple trying to get milk, he makes the nipples sore. If engorgement is not taken care of, it can lead to a problem called "caking", where a milk gland gets completely blocked. A caked milk gland can become infected (called mastitis) and this can be serious, too. None of this has to happen, so be sure to read the part on how to prevent engorgement.

2. Sore Nipples - Another problem that new breast feeding mothers may have is sore nipples. This problem can be prevented, too, for most people. Here is how to prevent sore nipples:

   a. Do not use soap or alcohol on the nipples and breasts. These things dry out the skin and can cause the skin to crack. Wash your breasts and nipples only with plain warm water. If you have very tender skin, you may want to wipe off the nipples with a wash cloth after each feeding to wipe away any milk left there.

b. DO NOT use plastic inside your bra. Use only cotton cloth to soak up any leaking milk (a man's handkerchief works very well). Plastic holds in heat and wetness and will cause your nipples to be sore.

c. Practice nipple rolling or nipple conditioning before delivery. After you have the baby, roll the nipple before nursing so the baby can get it in his mouth right. Be sure the baby does not just chew on the nipple.

d. If the baby is very hungry, express some milk before nursing. This speeds up the let-down reflex and means that the baby doesn't have to suck hard for very long before he gets some milk.

Taking care of sore nipples:
If you do get sore nipples, here is what to do about them:

a. Follow all the things that were just listed for preventing sore nipples.

b. When you nurse, start the baby on the nipple that is least sore. That way, the baby will not have to suck as hard on the sore nipple. Be sure that you still nurse on both breasts.

c. After nursing, expose your nipples to air for 10-15 minutes. You can do this by leaving the flaps of your bra down. If you have a private window where you could sit with the sun on your breasts, that is very good. Sunlight really helps to heal sore nipples.

d. Use a good nipple cream to keep the skin soft and to help cracked nipples heal. Lanolin, or Vitamin A & D Ointment, are very good for healing sore nipples. You can buy these creams at the drug store. Put the nipple cream around the nipple and areola after nursing each time and then gently wipe it away before nursing again.

SPECIAL NOTE FOR MOTHERS WHO ARE NOT BREAST FEEDING

How to Take Care of Engorgement

If you do not plan to breast feed your baby, you'll be given a shot in the delivery room to help dry up your breasts. Sometimes this shot doesn't work very well. If you become engorged, here are some things you can do to help:

1. Wear a fairly tight supportive bra (not too tight or it will cut off the blood flow).
2. Use ice packs to relieve discomfort.
3. Take Tylenol, if needed.
4. DO NOT express or pump out the milk - the breasts will only make more milk.

It usually takes 1 or 2 weeks to dry up the breasts.

B. BREAST FEEDING AS THE BABY GROWS OLDER

Feeding "schedules"

In the hospital, and the first few weeks at home, you will probably find that your breast fed baby gets hungry every 2 to 3 hours. Remember that it is important to nurse the baby on demand when he is hungry. Don't try to put the baby on a stiff clock schedule -- he can't tell time! His stomach tells him when he is hungry. The breast fed baby will usually need to eat more often than the bottle fed baby because the breast milk is digested faster and more easily. As your milk supply gets going well, and the baby gets older, the baby will settle down to a pretty regular "schedule" of eating about every 3 to 4 hours.

Giving bottles

Remember that the breast and the milk supply work on the supply and demand system: the breast will make enough milk only if the baby is nursed. It takes from 2 to 6 weeks to get the milk supply going well, and it is very important that the baby not be given bottles of formula or any other foods during that time. If you need to go out to some place where you can't nurse the baby, you can do a couple of things. One way to do it is to go between feedings -- feed the baby just before you go, and again as soon as you get back.

Another way to do it, if you know you will have to be gone at a feeding time, is to express your milk by hand into a bottle for the baby.

Why is it so important to not give bottles of formula? There are several reasons why formula causes trouble for breast feeding mothers and babies:

1. The baby uses different muscles to nurse from the breast than to drink from a bottle. It is very confusing for the baby to switch back and forth.

2. Formula is harder to digest than breast milk, and formula takes longer to digest. If you give the baby a bottle after nursing, or between feedings, he will not nurse well the next time you breast feed. That means that you may get problems with engorgement and less breast milk.

3. If a mother gives a bottle of formula instead of a breast feeding, the breasts will become too full (engorgement). Please go back to the section on engorgement to remind you of what that is. Remember that the baby finds it very hard to nurse from engorged breasts.

4. If baby is given formula instead of breast milk, or right after nursing, it will cut down on the amount of milk the mother has. That is fine if you are trying to wean the baby from the breast, but not if you still want to breast feed.

Can I ever give the baby a bottle of formula? Yes, if you really need to, but not until after your milk supply is going really well! Wait until the baby is at least 4 to 6 weeks old when you give a bottle of formula, and be sure that you hand express or pump out the breast milk. That way your breasts will know that they still need to make milk.

Growth Spurts

All babies have times when they start to grow very fast and need more food. Even though bottle fed babies also have these "growth spurts", they are most noticeable in breast fed babies. Growth spurts happen more commonly at about 1-2 weeks, 5-7 weeks, and 3-4 months. The happy, contented baby who has been nursing every 3-4 hours may suddenly seem hungry and want to nurse more often. THIS DOES NOT MEAN THAT YOU HAVE LOST YOUR MILK. It means that you need to nurse the baby more often until your milk supply catches up. Just go ahead and nurse the baby on demand and be sure you drink plenty of fluids. In 2 or 3 days your milk supply will catch up and baby will go back to his regular schedule again. Whatever you do, do not give the baby formula after breast feedings or in between breast feedings since that will only cause you to have less breast milk.

Giving solid foods

Most breast fed babies do not need other foods, except water, until they are 4 to 6 months old. Even bottle fed babies should not be started on solid foods until they are at least 4 months old. So why make a lot of fuss and bother about something the baby doesn't need? And remember, if you do give solid foods, that will cut down the amount of breast milk that you have.

By about 4 to 6 months, your breast fed baby will start to need more iron in his diet, so you should start giving some solid foods.

Here is a chart that will help you with what foods to start when. You will notice that the chart has the times for bottle fed babies, too, so you can use this chart even if you have stopped breast feeding.

Food	When to Start for	
	Breast fed Babies	Bottle fed Babies
CEREAL - Start with rice cereal first, a small amount once each day. Try one cereal for a whole week before going to another kind. After rice, try oatmeal, then others. DO NOT give mixed cereals till baby has tried each one alone. Use the dry packaged baby cereals, not cereal in a jar. The jar cereals do not have as much iron.	4-6 months	4-6 months
FRUITS - Give plain fruits with no sugar added. Start with mild fruits like applesauce or pears. It is best to make your own at home by grinding or blending plain cooked fruits. Give one fruit for a week before adding a new one. DO NOT give mixed fruit until baby has had each fruit alone.	5-7 months	5-6 months

Food	When to Start for	
	Breast fed Babies	Bottle fed Babies
FRUIT JUICE - Start with apple juice and dilute half and half with boiled water. DO NOT give mixed fruit juice until the baby has tried each juice alone. DO NOT give orange juice till baby is at least 6 months old because it causes allergy in some babies.	5-7 months	5-7 months
VEGETABLES - Give plain vegetables with no salt or sugar added. Start with mild vegetables like carrots or green beans. It is best to make your own by grinding or blending plain soft cooked vegetables. Give one vegetable for a week before adding a new one. DO NOT give mixed vegetables until baby has tried each one alone. DO NOT give baby corn because it is very hard to digest and may cause allergy in some babies.	5-7 months Some mothers start vegetables before fruits because the fruits are naturally sweet and baby likes the sweet taste.	5-7 months
MEATS - You can prepare your own baby meats by grinding or blending well cooked meat with no extra fat, salt, or other seasoning added. If you use the ready-to-eat baby meats, check the label to be sure no salt or sodium nitrate are added. Give plain meats, starting with chicken or turkey. Give one kind of meat for a week before adding a new one. STAY AWAY from mixed dinners since these have more starch and less meat value than plain meats. DO NOT give HIGH-MEAT DINNERS. These overload baby's kidneys.	7-8 months	7-8 months
EGG YOLK (yellow) - Give the yellow part of hard-boiled egg, mashed and mixed with milk or water. Start with ¼ to ½ of egg yolk each day. DO NOT give white part of egg till about 1 year of age since it may cause allergy in younger babies. Egg yolk in jars is expensive. What you fix at home may be better and doesn't take much time.	7-8 months	7-8 months

Food	When to Start for	
	Breast fed Babies	Bottle fed Babies
PINTO BEANS - Give strained or mashed beans with no fat, salt or chile added. Mix some of the bean juice with the strained beans for the right thickness. Give in place of meat for a meal.	7-8 months	7-8 months
"TABLE FOODS" - If you make your own baby foods, you will be giving "table foods" all along. Most babies can begin to eat table foods, mashed, when they start to get teeth they can chew with. Foods like mashed potatoes may be given earlier, but not too much at one time.	When baby seems ready	When baby seems ready

Weaning from the breast

Sooner or later you or the baby, or both of you, will decide it is time to wean from the breast. Some babies will wean themselves if given the chance. If the baby is 7 to 8 months old and knows how to drink from a cup, it may be best to wean from the breast to the cup without giving bottles. Choose one of the formulas that is close to mother's milk to give the baby instead of breast milk. DO NOT GIVE WHOLE COW'S MILK UNTIL THE BABY IS AT LEAST 9 MONTHS OLD.

It is best for both you and the baby to wean from the breast slowly, not all of a sudden. Stretch the weaning period out over 2 or 3 weeks, and remember that the baby may still want to nurse before going to bed at night or at times of stress (teething, falls and bumps, etc.) Start weaning by giving a cup or bottle instead of breast feeding for one feeding. Usually it works best to do this at the breast feeding which is the lightest of the day. After 2 or 3 days, give the cup or bottle at two feeding times and so on. By slowly cutting down the amount of time the baby nurses at the breast, you will make it easier on the baby and your milk will slowly dry up. You do not need to go through the sometimes painful problems with engorgement that you would have if you wean the baby suddenly. If you wean the baby to a bottle, BE SURE TO HOLD THE BABY FOR FEEDINGS. HE STILL NEEDS THE CLOSENESS AND SAFE FEELING HE HAS HAD AT FEEDING TIME.

Questions, answers and stories

Here are some common questions and their answers, and some of the stories you may hear about breast feeding. Maybe this will help you answer some of your own questions.

Q. Is there any special food I should eat or not eat when I am breast feeding?

A. No, just be sure to eat good balanced meals. There are no foods that you can't eat, but remember that too much of anything is not good. There is also no special food to make "super milk", in spite of the stories you may have heard about beer or other things.

Q. Someone asked me if my milk was rich enough. What about that?

A. Breast milk normally looks a little thin and may have a sort of blue color to it. Many people see this milk and think it isn't "rich" enough because it doesn't look like cow's milk. This thin, blue color is normal for breast milk. You will notice that after the baby has nursed for 5-7 minutes, the milk looks creamier. That is because the last milk in the breast (called the "hind" milk) does have more fat in it and is creamier. It is important to nurse the baby at each breast long enough for him to get this "hind" milk so that he will get enough of the creamy milk.

Q. How can I be sure that the baby is getting enough milk?

A. There are several things that you can use to tell if you baby is getting enough:

1. if the baby has 6-8 wet diapers each day
2. if the baby seems satisfied for 1-2 hours after feeding (most brand new babies sleep from one feeding to the next)
3. if the baby seems to be gaining weight and is active while awake

Put these things together. If your baby nurses well, seems satisfied after nursing, is gaining weight and has 6 to 8 wet diapers each day, he is most likely getting plenty of milk.

Q. What do I do if my baby doesn't seem to be gaining quite enough weight?

A. First of all, how much should a baby gain? Most babies lose a little weight the first few days after birth; then they start to gain. The baby should usually be back to his birth weight at about two weeks of age. After that, a weight gain of about 3/4 to 1¼ ounces per day is good weight gain. Babies usually double their birth weight between 5 and 7 months and triple it at about a year.

If the baby doesn't seem to be gaining quite as much as he should, you will want to take a look at what you are doing. (1) Are you drinking enough fluids? You need from 8-16 glasses of fluid each day. (2) Are you nursing the baby often enough and long enough? Remember to feed baby on demand, about 10-15 minutes on each breast at each feeding. (3) Is the let-down reflex working? Does the milk flow freely in small drops when the baby nurses? Are you too tired, not eating enough, or really up-tight? All those things can get in the way of a good milk supply.

Try to take a close look at what is going on with you and the baby. Then try to change the things that don't seem quite right. If babies are fed often enough and long enough, and if mother is drinking enough fluids and eating well, most babies will gain weight just fine.

Q. What if I have to go out somewhere that I can't take the baby? Or what if it's not a place where I could breast feed the baby?

A. There are many ways to fix your schedule so that you don't have to miss a feeding. It is also possible to nurse a baby almost any place without being embarrassed. (You can toss a blanket over your shoulder and baby, and no one will know, if they even notice.) If you just can't do those things, you can hand express your milk and put that into a bottle to leave with the baby or to take along. Breast milk can be kept in the refrigerator for one day, or frozen in the refrigerator-freezer for up to 2 weeks.

Q. Some of my family don't like it because they can't feed the baby. What can I do about that?

A. There are many ways for other people to share in the baby care and baby loving besides feeding. Why not share the bath time or just plain holding and rocking? If you give your baby water between feedings, let someone else give it -- the baby may not take it from you anyway since he can smell the milk. Some mothers like breast feeding just because it is something no one else can do for the baby!

Q. What if I get sick and can't nurse the baby for a few days?

A. The biggest problem with nursing the baby when you are sick is if you have to take medicine. Ask your doctor if the medicine would hurt the baby. If it seems best for you to not nurse while you are taking medicine, you can give the baby formula for a few days and keep up your milk supply by hand expressing or pumping out your milk. Then start nursing again as soon as you can.

Q. What if the baby is sick?

A. It is even more important to nurse the baby if he is sick. He really needs the closeness and safe feeling when he doesn't feel good, even if he doesn't nurse very well.

Q. Can I get pregnant while I am breast feeding?

A. YES. Even though many women do not have periods for quite a while when they are completely breast feeding, there is still a chance of your ovaries releasing an egg. Breast feeding is not a good form of birth control -- you should always use a method that you can count on.

Q. What about birth control pills?

A. It is the feeling of most people now that a breast feeding mother should not take birth control pills. There are several reasons for this: (1) birth control pills cut down the amount of milk you have; (2) birth control pills may cut down the quality of the milk (how good it is); and (3) we don't know what the birth control pills might do to the baby. Rather than take a chance, why not use one of the other good methods of birth control?

Q. What about sex and breast feeding?

A. This is up to each mother. Many mothers find sex more enjoyable at this time; others don't notice any difference in how they feel about sex. You will need to take a look at how you feel about this. Remember, the breast is and can be both a sexual organ and a baby feeder. One thing that may scare or surprise many women is how good breast feeding feels after they get over the little bit of soreness they may have at first. This good feeling is normal, and not anything to be ashamed of. Many breast feeding mothers say it is one of the most beautiful feelings in the world.

Q. What if the baby is premature?

A. It is very important for a premature baby to be given breast milk. Even if the baby has to stay in the hospital for a while, you can keep up your milk supply by expressing the milk. Many hospitals now will give you special jars to put your milk in so that you can take it to the hospital for the baby. Start nursing at the breast as soon as the baby is strong enough.

Are you still not sure about how you will feed the baby? Why not at least try breast feeding. Give yourself at least 2 or 3 weeks, and if you don't like it, you can always stop.

If you would like to read more about breast feeding, here are a few books to look for:

The Complete Book of Breastfeeding by Marvin Eiger and Sally Wendkos Olds. 1972. Bantam Books. $1.50 paperback.

Nursing Your Baby by Karen Pryor. 1963. Harper & Rowe. New York

The Womanly Art of Breastfeeding by La Leche League International. 1958. $3.00 paperback from La Leche League.

Exercise Booklet

for

TEENAGE PREGNANCY: A NEW BEGINNING

by

Linda Barr, R.N., M.N.

Catherine Monserrat, M.A.

Illustrations by
Kim Behm

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PART ONE: PREPARING FOR CHILDBIRTH

The exercises in this section can help you get ready for the birth of the baby. They can also help you look and feel better during pregnancy. Begin to do the exercises to strengthen muscles and the relaxation exercises early in your pregnancy. Begin to do the breathing exercises by the beginning of the seventh month to be well prepared for labor and delivery. You will need to practice these exercises every day for fifteen to twenty minutes.

If any of these exercises cause pain, stop doing them and check with your doctor. You will be more comfortable if you go to the bathroom before you start to exercise. Wear loose, comfortable clothing while exercising.

Section One: EXERCISES TO STRENGTHEN MUSCLES

These exercises will keep your body in good shape during pregnancy. They will help build the muscles you will use during labor and delivery. And they will help you get your figure back quicker after the baby is born. You can start these exercises early in pregnancy.

A. Good Posture

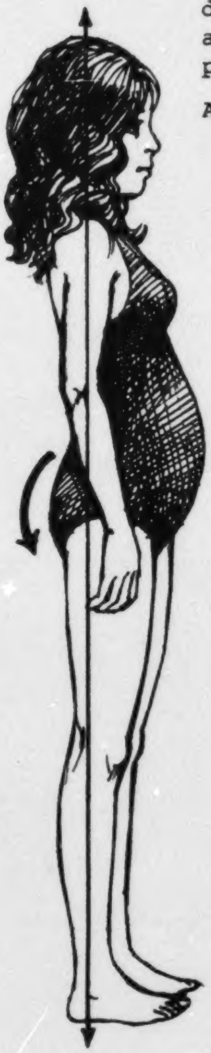
Purpose: Helps you keep from getting a backache or getting tired.

Position 1: Stand with knees straight but not tight, legs apart a few inches, and feet flat on the floor.

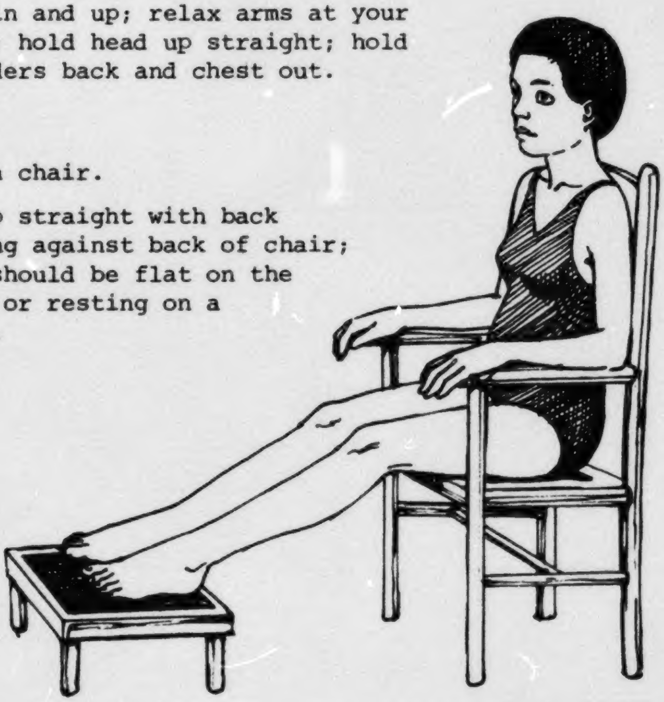
Exercise 1: Tuck in your bottom; tighten the muscles in your abdomen, pulling them in and up; relax arms at your sides; hold head up straight; hold shoulders back and chest out.

Position 2: Sit in chair.

Exercise 2: Sit up straight with back resting against back of chair; feet should be flat on the floor or resting on a stool.



POSITION 1



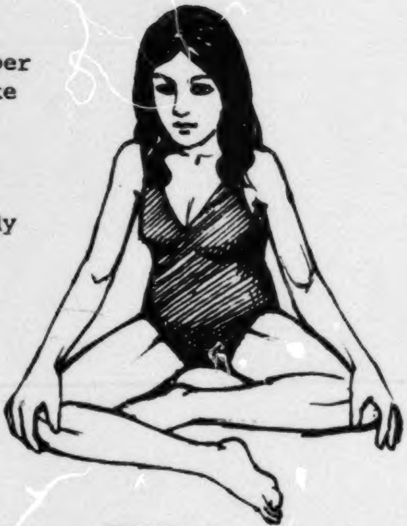
POSITION 2

B. Tailor Sitting

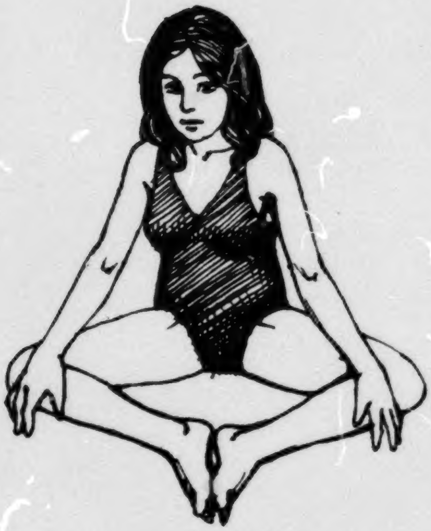
Purpose: Stretches muscles on the inside of upper legs and around birth canal; helps make delivery easier.

Position 1: Sit on floor with legs bent, knees and outside of legs resting on the floor; heels should be close to body with one resting in front of the other (do not cross ankles). Rest back against wall or couch.

Exercise 1: Sitting in this position is the exercise! You can do this while studying, watching TV, or during many other activities.



POSITION 1



POSITION 2

Position 2: Sit with knees apart, bottom of feet together, and heels close to body.

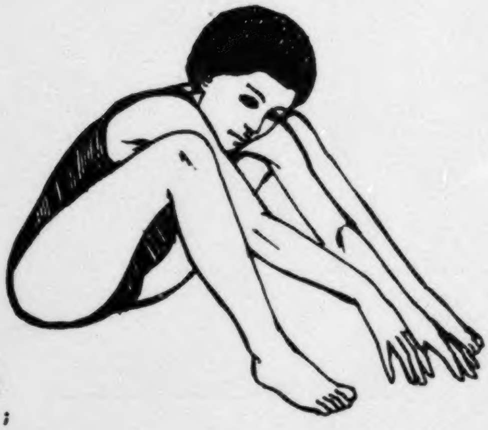
Exercise 2: Gently push knees toward the floor. Bring knees back together. Repeat 5 to 10 times.

C. Tailor Stretch

Purpose: Same as tailor sitting; also helps stretch and strengthen back muscles.

Position: Sit with knees bent, legs open wide, feet flat on the floor.

Exercise: Extend arms; gently lean forward as far as you can (don't bounce); hold for a few seconds, then return to normal position. Repeat 5 to 10 times.



D. Kegal

Purpose: Makes the muscles around the birth canal stronger.

Position: Sit; stand; or lie down.

Exercise: Pull in and tighten the muscles around the vagina; hold a few seconds; relax. Repeat as often as you can; can be done any time.

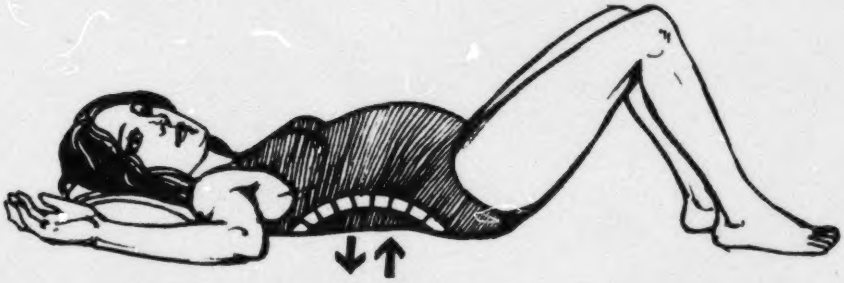
NOTE: To find these muscles, try to stop the flow of urine when you go to the bathroom.

E. Pelvic Rock

Purpose: Helps to make back muscles stronger; relieves backache.

Position 1: Lie on back, knees bent, feet flat on floor. (A pillow under your head may make you more comfortable.)

Exercise 1: Tighten bottom and press the small of your back against the floor; hold for a few seconds; relax. Repeat slowly several times.

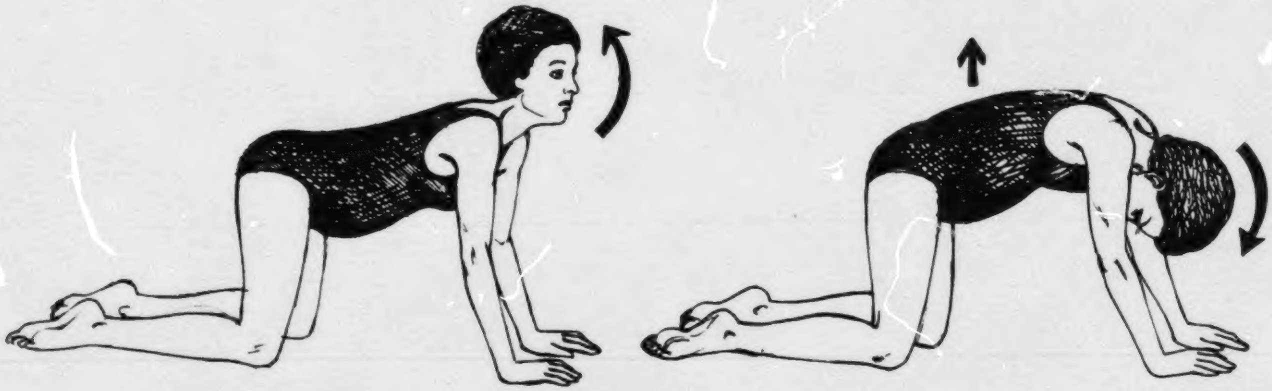


POSITION 1

Position 2: Get on your hands and knees, with your shoulders directly above hands, and hips above knees.

Exercise 2: Relax back muscles, lift head up; hold; now, slowly lift your back up, pull in abdomen, and drop head; hold. Repeat slow up-and-down motion several times.

NOTE: If you are doing this right, your shoulders won't move. Your hips will rock up and down.



POSITION 2

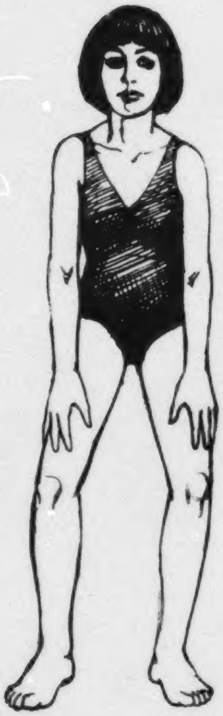
F. Squatting

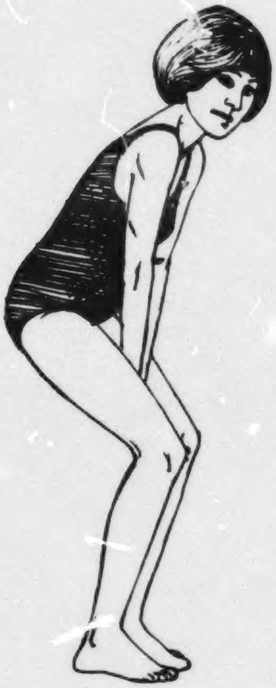
Purpose: Stretches and strengthens the muscles around the birth canal; helps make delivery easier.

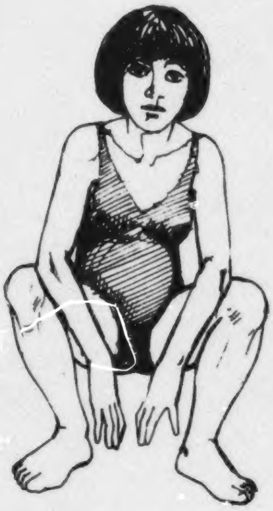
Position: Begin in a standing position with feet flat on floor about 12 inches apart, and legs spread apart.

Exercise: With knees apart, slowly lower body to a squat; rest arms between legs or on knees and keep back as straight as possible. Try to keep your feet flat. Hold for as long as you can.

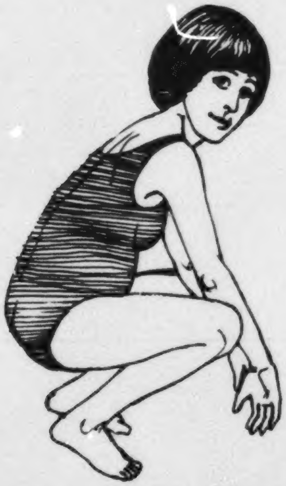
NOTE: Learn to squat for at least three minutes.

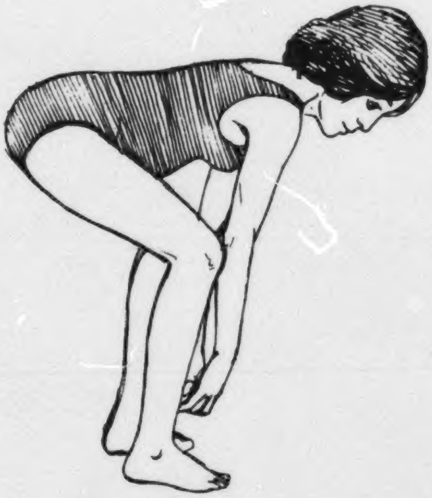






To get up, lean forward slightly and use leg muscles to help you stand.





G. Ankle Rotation

Purpose: Helps blood flow better in your legs; relieves muscle cramps in legs and feet.

Position: Sit on the floor with your legs out in front of you; support your body with your hands.

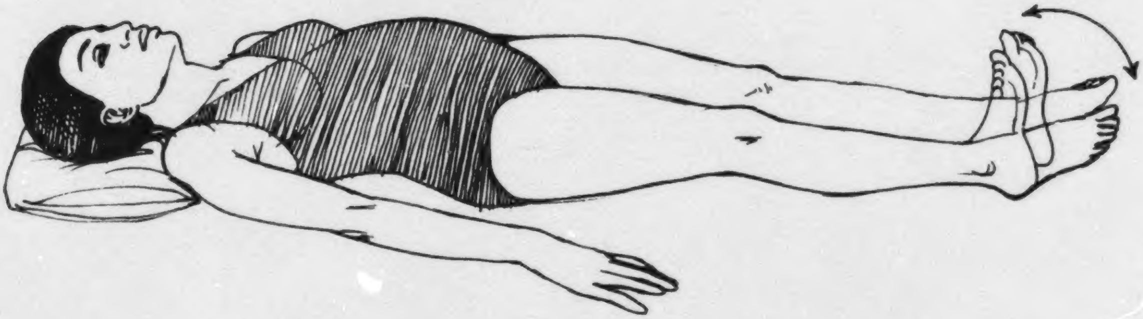
Exercise: Lift right foot a few inches off the floor; slowly make a circle with your foot by moving your ankle. Repeat 10 times with each foot.

H. Calf Stretching

Purpose: Relieves leg cramps.

Position: Lie on back, legs flat.

Exercise 1: Pull toe toward knee as far as you can, keeping knees straight.



Exercise 2: Push foot flat against wall or someone's hand; keeping knees straight.

Exercise 3: Walk around.

Section Two: EXERCISES TO RELAX THE BODY

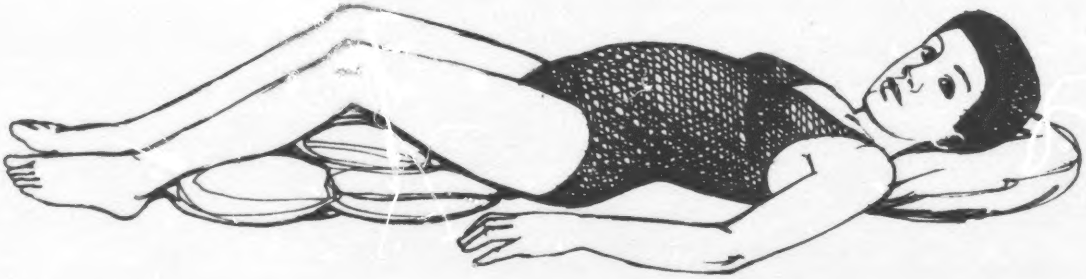
Learning to relax is important for many different reasons. During pregnancy, it helps relieve tension in your mind and body, helping you to feel calm and secure. Relaxing also helps you save energy. It is very important for relieving tension and pain during labor. Being able to relax is helpful in coping with the ups and downs of life.

There are two keys to relaxing: the position of your body and how you breathe. Begin learning to relax your body now!

A. Back Position for Relaxation

This position will be more comfortable early in pregnancy than in the later months.

Position: Lie on back with one or more pillows under your head and one under your knees; let your arms rest naturally at your sides with your feet slightly apart.

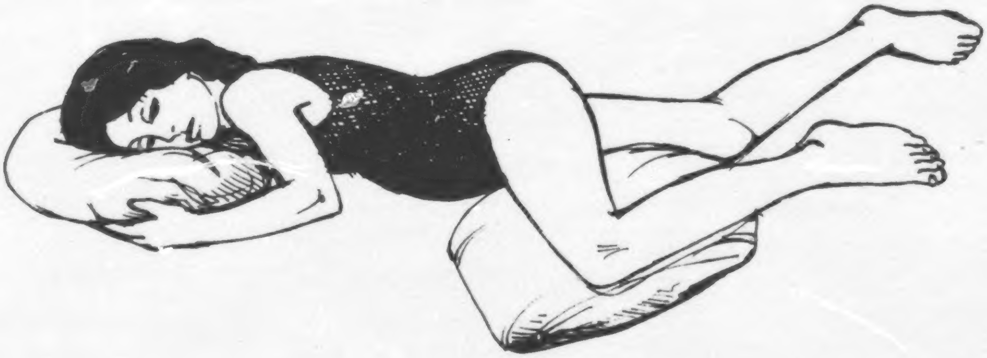


B. Lying on Side Position for Relaxation

This position will be more comfortable as your abdomen gets larger. It is often a comfortable position during labor.

Position: Lie on your side with your head on one or two pillows; bend knees and support your upper knee on a pillow; rest arms where comfortable.

NOTE: You may want to put another pillow against your back for support.



C. Breathing for Relaxation

Slow, even breathing helps body and mind relax.

Exercise: Breathe in as deeply as you can. Then, blow the air out slowly, letting your body go limp. Keep breathing quietly and slowly. As you breathe in, think to yourself, "I am...". As you breathe out, think, "...relaxed." Continue this, letting your body feel loose and heavy.

D. Muscle Relaxing Exercise

You will learn how the body feels when it is relaxed and how to relax tense muscles. This will control muscle tension and relieve pain during labor.

Position: Lie on back or side.

Exercise: Begin by controlling your breathing. Tighten and relax each part of your body in the following order. Start with the left side of your body:

Bend toes under . . . . relax
Bend toes up . . . . relax
Bend foot down . . . . relax
Bend foot up . . . . relax
Tighten leg . . . . relax
Tighten hip . . . . relax
Make a fist . . . . relax
Tighten arm against body . . . . relax
Tighten shoulder muscles . . . . relax
Tighten face muscles . . . . relax

Repeat on right side of body, leaving left side relaxed. Relax all over and rest for a while. Practice relaxing your muscles every day. You may sleep better if you do this after you have gone to bed.

Section Three: BREATHING EXERCISES FOR LABOR AND DELIVERY

You may wonder why you have to learn to breathe when it's something you do all of the time! During labor, you can be more comfortable if you learn to breathe in a new way. It can help you to relax and will give your baby the oxygen he needs. Also, the special breathing gives you something to think about besides contractions. During labor, it may become hard for you to concentrate on your breathing. It will be easier if you have someone with you to help you. If you can, practice these breathing exercises with this person ("coach") every day. Start practicing these breathing exercises no later than your seventh month of pregnancy.

For more information on labor and delivery, read chapters 9, 10, and 11 in Teenage Pregnancy: A New Beginning.

A. Complete or Cleansing Breath

Purpose: Done before and after every contraction as a signal to begin and end special breathing; fills lungs with oxygen.

Position: Lie on back or side; or sit.

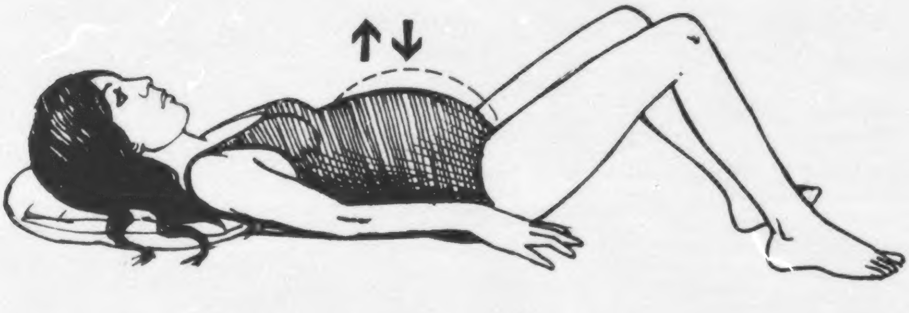
Exercise: Breathe in once as deeply as you can. Blow the air out slowly, relaxing your whole body. Then you are ready to begin the special breathing.

B. Abdominal Breathing

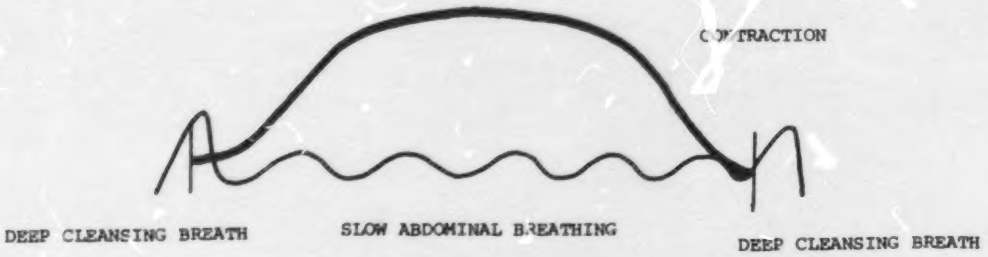
Purpose: Helps all muscles relax and gives the baby oxygen; allows the muscles of the uterus to work better; helps to save energy and relieves pressure.

Position: Lie on back or side; or sit.

Exercise: After taking the deep, cleansing breath, breathe in and out slowly and evenly. The abdomen will rise and the chest should not move. As you do this, pretend your abdomen is a balloon, filling up with air. Take a deep, cleansing breath at the end of the contraction.



Abdominal breathing is done with each contraction during most of the first stage of labor. Breathe normally between contractions. Practice by pretending that you are having contractions that last from 30-45 seconds. Practice every day.

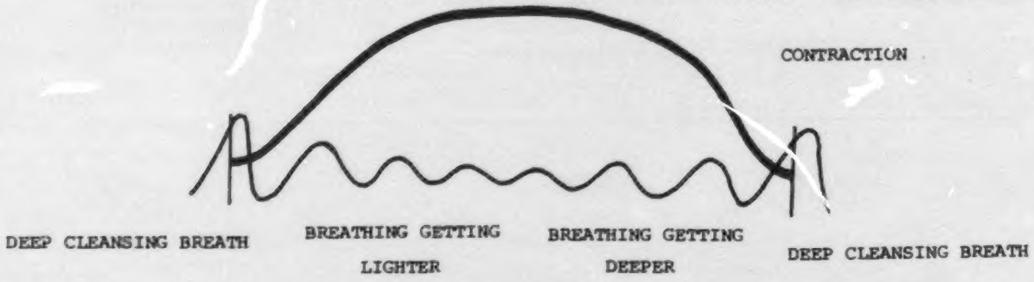

CONTRACTION
DEEP CLEANSING BREATH
SLOW ABDOMINAL BREATHING
DEEP CLEANSING BREATH

C. Light, Shallow Breathing

Purpose: Keeps you from holding your breath as contractions get stronger; continues to give mother and baby a good oxygen supply.

Position: Lie on back or side; or sit.

Exercise: Take a deep cleansing breath and relax. Breathe lightly in your chest and throat. As your contraction gets stronger, each breath should get lighter and shallower than the breath before. As the contraction begins to go away, each breath should become a little deeper. If you become dizzy or lightheaded, your breathing is too hard and fast. Take a quick, deep breath and slow down. At the end of the contraction, take a deep, cleansing breath.


CONTRACTION
DEEP CLEANSING BREATH
BREATHING GETTING LIGHTER
BREATHING GETTING DEEPER
DEEP CLEANSING BREATH

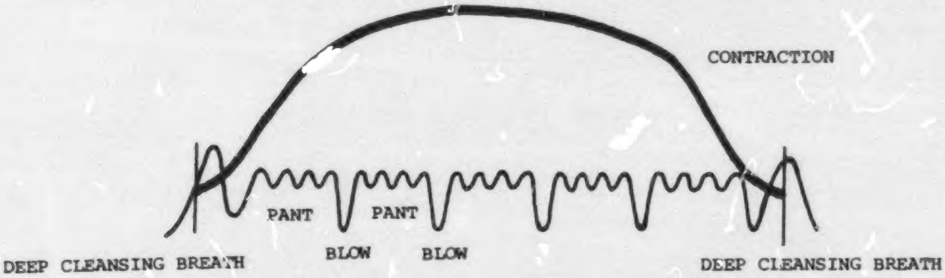
Light, shallow breathing is done near the end of the first stage of labor, during transition. Breathe normally between contractions. Pretend you are having contractions that are lasting almost a minute. You soon will find your own comfortable speed and rhythm if you practice shallow breathing every day.

D. Panting and Blowing

Purpose: Keeps you from holding your breath and pushing too soon; may be used during delivery to keep you from pushing the baby out too quickly.

Position: Lie on back or side; or sit.

Exercise: Breathe in and out very quickly with your mouth open -- like a panting dog. It may help if you blow or puff out the air every 3 or 4 breaths. Take a deep, cleansing breath when the contraction is over.


CONTRACTION
PANT
PANT
BLOW
BLOW
DEEP CLEANSING BREATH
DEEP CLEANSING BREATH

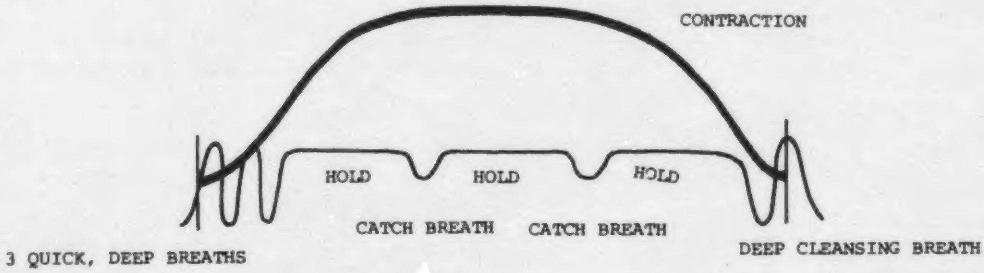
Panting and blowing are done during transition and during delivery. You may feel a strong need to push at these times. Learning to pant will help you control this need. Push only when the doctor tells you to. Practice every day! You should learn to pant for a minute at a time.

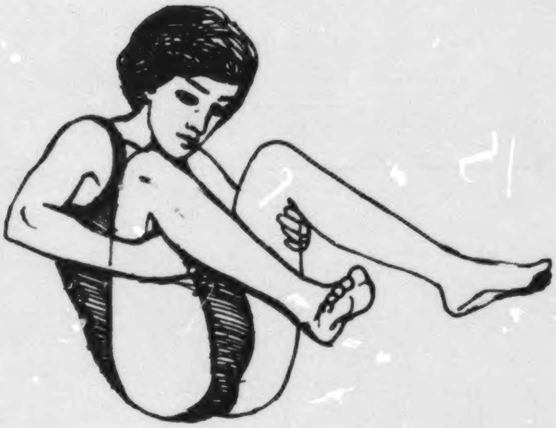
E. Pushing

Purpose: Helps you push the baby out during delivery.

Position: Lie on back with head and shoulders raised in a half-sitting position; knees are bent and legs are wide apart. It may be easier if someone (your coach) supports your back.

Exercise: Take 3 deep breaths as quickly as you can. Hold the third breath. Hold your legs behind the knees and pull them up to your chest. Hold your breath for as long as you can. Do not push while practicing. When you can't hold your breath any longer, take a "catch breath". To do this, throw your head back, breathe out, and take another deep breath. Bring your head forward again and hold your breath. Practice for 1 minute, taking no more than 2 or 3 "catch breaths". When the contraction is over, relax and take a deep, cleansing breath.


CONTRACTION
HOLD
HOLD
HOLD
CATCH BREATH
CATCH BREATH
3 QUICK, DEEP BREATHS
DEEP CLEANSING BREATH



Pushing is done during the second stage of labor. Push only when the doctor or nurse tells you to. Pushing too soon can make your labor longer and will make you tired. Practice holding your breath in the pushing position every day; but, DO NOT PUSH!

PART TWO: POSTPARTUM EXERCISES

Exercise is worth your time. It is good for both your body and your mind. After the baby is born, you will be excited about getting your figure back. Postpartum exercises will help strengthen the muscles that were stretched during your pregnancy, labor and delivery. If you do these each day, you will soon have more energy and your figure will look better. The better you look, the better you'll feel about yourself.

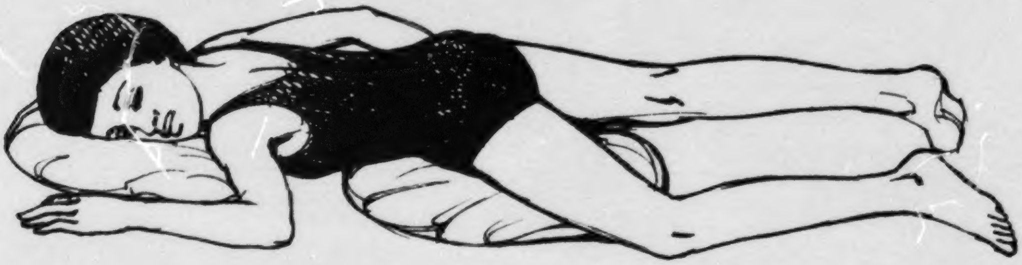
You will be able to begin these exercises soon after the baby is born. Check with your doctor to find out when it is safe for you to begin. If you have had a normal labor and delivery, there are some simple exercises you may feel like doing while you're still in the hospital.

Some of the exercises you did during pregnancy are still good for you now. You will want to continue with the controlled breathing, good posture, and Kegal exercises. The controlled breathing will still help you relax when you are uptight or tense. Good posture will help your figure look better. The Kegal exercise will tighten the muscles of your vagina that were stretched during delivery. You can start these as soon as you feel like it.

Section One: EXERCISES TO BEGIN IN THE HOSPITAL

A. Lying on Abdomen

You may be very happy to know that you can once again lie on your tummy! In fact, this is a very good position for you after you have delivered. It helps the uterus return to its normal place. Your back may be more comfortable if you put a pillow under your hips. Lie on your abdomen at least 20 minutes a day.



B. Walking

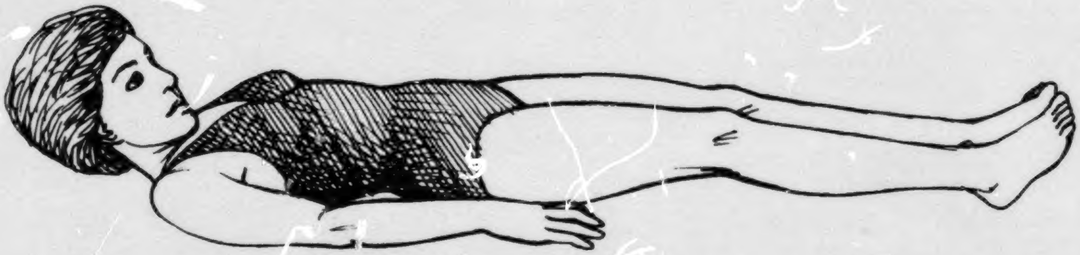
Soon after delivery, the nurse will probably want you to get up and walk around. You may feel a little shaky the first few times you are up. Have someone help you until you feel steady on your feet. Walking will help your blood flow better in your body which helps you feel stronger. Continue to take walks after you get home.

C. Head Lift or "Chin Chest"

Purpose: Helps tighten abdominal muscles.

Position: Lie on back, arms and legs straight and relaxed.

Exercise: Breathe in slowly through your nose and let your abdomen rise. Slowly blow the air out through your mouth as you tighten your abdomen as hard as you can. As you blow out, lift your head off the bed and put your chin on your chest. Hold a few seconds and then relax. Repeat 5 to 10 times twice a day.

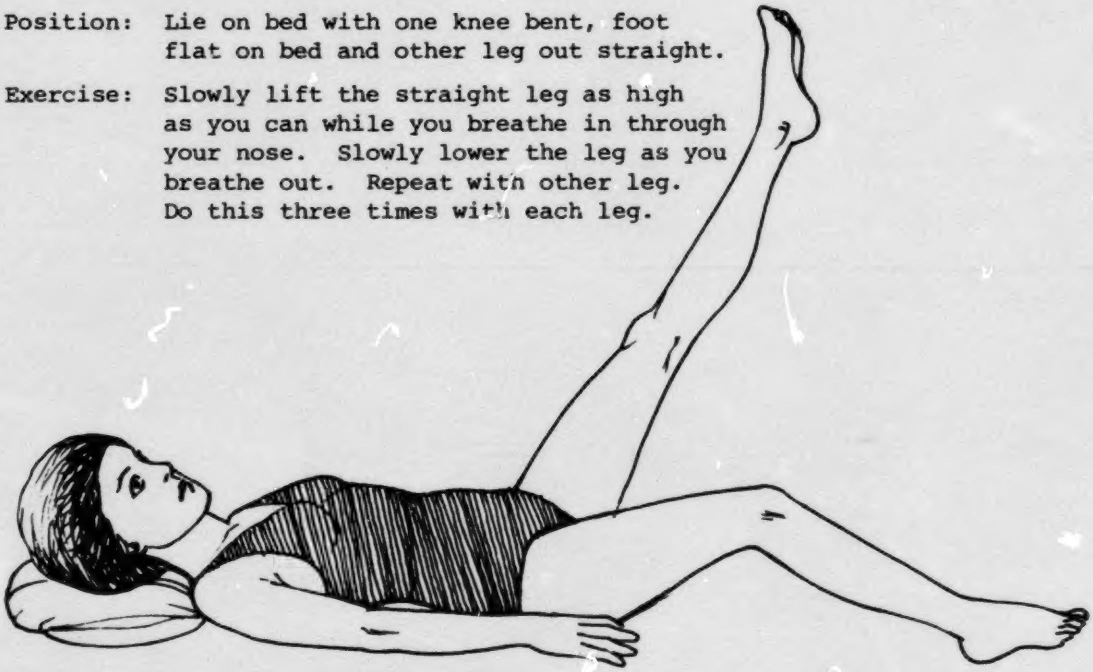


D. Leg Lift

Purpose: Helps tighten abdominal muscles.

Position: Lie on bed with one knee bent, foot flat on bed and other leg out straight.

Exercise: Slowly lift the straight leg as high as you can while you breathe in through your nose. Slowly lower the leg as you breathe out. Repeat with other leg. Do this three times with each leg.



Section Two: EXERCISES AFTER YOU ARE STRONGER

After you go home from the hospital, you will get stronger each day. You may feel like doing more exercises. Ask your doctor when he thinks it is OK to begin these.

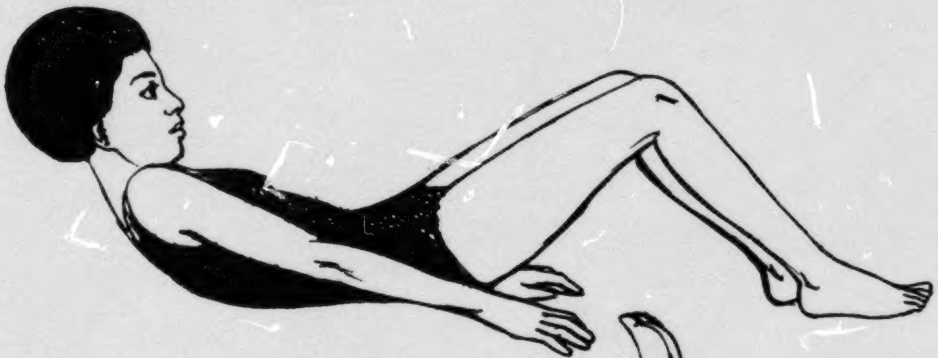
A. Partial Sit-ups or Progressive Chin Chest

Purpose: Tightens abdominal muscles.

Position: Lie on back with knees bent and your feet flat on the floor.

Exercise: Raise your head and shoulders and try to come to a sitting position. Hold for a few seconds, then lower your head and shoulders and relax. Repeat 3 to 5 times.

NOTE: The stronger you get, the closer you will get to complete sit-ups. A complete sit-up is your goal!

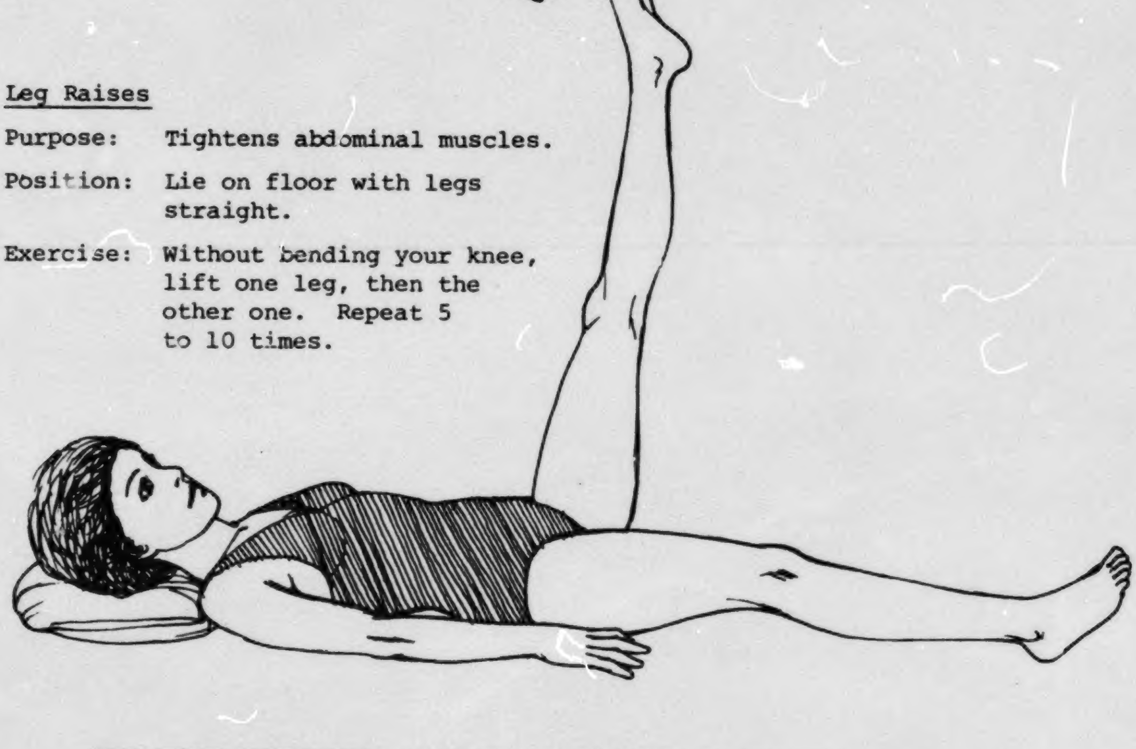


B. Leg Raises

Purpose: Tightens abdominal muscles.

Position: Lie on floor with legs straight.

Exercise: Without bending your knee, lift one leg, then the other one. Repeat 5 to 10 times.



FOR OTHER EXERCISES, ASK YOUR DOCTOR WHAT HE RECOMMENDS.

NEW FUTURES SCHOOL

STATISTICAL SUMMARY - 1977-1978

Total Number of Clients Served:

- In classes: 257
- Babies in nursery: 82
- Number of services to family members: 271
- Number of services to young fathers: 110
- Individual and Group services to non-enrolled students: 682
- Number of young mothers served in Freedom High counseling groups: 66
- Number of clients served since program inception (January, 1970): 1,345

Average Daily Enrollment - 20-day reporting:

September 22	87	February 1	115
October 20	95	March 2	112
November 21	107	April 6	125
January 4	118	May 4	130
June 2	91		

Demographic Data on Regularly Enrolled Clients:

Ethnic Background:	Anglo	70	(27.2%)
	Black	19	(7.4%)
	Chicano	155	(60.3%)
	Indian	10	(3.9%)
	Asian	3	(1.2%)
Residence:	Northeast	52	(25.7%)
	Northwest	51	(28.8%)
	Southeast	37	(17.5%)
	Southwest	61	(25.7%)
	Belen	1	
	Corrales	1	
	Isleta	2	(2.3%)
	Los Lunas	1	
	Jemez Pueblo	1	
	Other N.M.	25	(9.7%) **
	Other States	22	(8.6%)
Age:	13 years	2	(.8%)
	14 years	3	(1.2%)
	15 years	31	(12.1%)
	16 years	60	(23.4%)
	17 years	102	(39.7%)
	18 years	56	(17.9%)
	19 years	7	(2.7%)
	20 years	4	(1.6%)
	21 years	2	(.8%)

** Detailed list - page 11

Marital Status:		
	Married	62 (24.1%)
	Single	193 (75.1%)
	Divorced	2 (.8%)

Educational Information Regarding Regularly Enrolled Clients:

Grade in School		
	7th grade	3 (1.2%)
	8th grade	8 (3.1%)
	9th grade	16 (6.2%)
	10th grade	54 (21%)
	11th grade	110 (42.8%)
	12th grade	66 (25.7%)

Previous School Attended:

Albuquerque High	39
Albuq. High Nite	2
Albuq. Indian School	3
Cibola High	6
Del Norte High	12
El Dorado High	5
Highland High	21
Manzano High	12
Rio Grande High	42
Sandia High	5
School-on-Wheels	4
Valley High	27
West Mesa High	19
John Adams Mid-High	1
Garfield Mid-High	2
Taft Mid-High	1
Taylor Mid-High	1
Truman Mid-High	1
Van Buren Mid-High	1
Washington Mid-High	3
Out-of-town	50 **

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Classes Offered:

- Family Living I and II
- Child Development I and II
- Child Care
- English - Reading Improvement (grades 7-12)
- English - Communications (grades 9-12)
- Children's Literature
- College Preparatory English
- GED Preparatory English
- Physical Education
- United States History
- Your Community
- Biology
- Typing I and II and III
- Shorthand I and II
- Bookkeeping and Recordkeeping
- Mathematics (7th grade math through Algebra and Trigonometry)
- Sewing
- Home Arts
- Office Aide

Education Summary:

Total students enrolled:	257
Had dropped out of school prior to pregnancy:	75 (29%)
Came to NFS directly from another school:	182 (71%)

Future Education plans:

Graduated or Returned to school	72%
Take G.E.D.	2%
Work/Stay at home	23.5%
Undecided/unknown	2.4%

Summary of Previous Drop-outs:	75
Return to school	25 (33%)
Take G.E.D.	8 (11%)
Graduate	1 (1%)
Home/work	37 (49%)
Undecided/unknown	4 (5%)

Summary of Students leaving prior to delivery:	43 (17%)
Move out-of-town	18 (42%)
Return to school	4 (9%)
G.E.D.	1 (2%)
Transportation problems	4 (9%)
Work	3 (7%)
Bedrest	1 (2%)
Home	12 (28%)

Health Statistics Regarding Regularly Enrolled Clients:

Number of Deliveries:	150 (2 sets of twins)

Complications:

Caesarian Sections	11 (7.3%)
Toxemia	8 (5.3%
Breech delivery	1
Hemorrhage	2
Endomitritis	1
Post partum infection	3
Prolonged rupture of membrane	1
Fever	1

Miscarriages:	2 (1.3%)

Health of Baby:

Premature	9 (6%)
Low weight	12 (8%)
Respiratory distress	4
Jaundice	1
Microcephalic	1
Multiple external anomalies	1
Congenital abnormalities	1
Heart murmur + other anomalies	1
Turned-out foot	1
Undeveloped liver	1
In isolation for infection	2

Infant mortalities:

Interuteral	1 (cause unknown)
Fetal	1
Premature stillbirth	1
3-month-old died of virus	1

A former student's baby died 2 days after birth - necrotizing intercolitis.

Number of Babies Released for Adoption:	17 (11.3%)
Number of home visits by health staff:	135
Number of hospital and doctor visits by health staff:	44
Number of home visits by counselors:	18
Number of hospital and doctor visits by counselors:	8

Sources of Referrals:

Word-of-mouth	132	UNM Personnel	2
APS School Personnel	37	Private doctors	2
Chaparral Home	17	Probation office	2
M & I Project	11	Isleta Public Health	1
Birthright	6	Farmington clinic	1
Youth Development, Inc.	5	Human Services Dept.	1
Media information	5	Project CHIP	1
Private medical staff	5	Employment office	1
BCMC	4	Carlsbad Health clinic	1
Planned Parenthood	2	Location refugee agency	1

Staff:

Program Coordinator	1 - full-time
Secretary/Bookkeeper	1 - full-time
Receptionist	1 - full-time
Counselors	4 - 3 full-time; 1 3/4-time; 1 serves as Administrative Counselor
Para-professional Instructor	2 - full-time
Health Director	1 - full-time (also teaches)
Health Assistant	1 - full-time
Professional Teachers	9 - 6½ full-time equivalencies
Cook	1
Assistant Cook	1 - part-time
Family Planning Secretary	1 - half-time
Outreach staff	2 - part-time

The Health Director and Counselors are involved in team-teaching some classes, and one teacher also serves as individual nutritionist to the students.

Community Information Efforts:

Community Presentations	Number	Attendance
to adults	21	637
to adolescents	96	2781

In-Building Visits: 118 persons

Ann Ray, Santa Fe Alternative School
Dr. Arthur Salsberry, Vice-President, Medical Department, National Foundation, March-of-Dimes
Dr. Harold Webb, Treasurer, NACSAP
Vic Ornelas, National Community Service Representative, Levi-Strauss
Social Worker from Navajo Reservation
Day Care worker from Phoenix Program for School-Age Parents
C.H.R. Worker from Isleta Pueblo
Director of a Migrant Program in Oregon
Representatives of Dallas Department of Labor and two consulting firms
Linda Mellgren - DHEW Office of Adolescent Pregnancy Initiative, Washington D.C.
Representative of State Department of Education
Representative of H.E.W. and Department of Labor
Photographer and writer from Department of Labor

There were also numerous visits from UNM students, APS staff, and Albuquerque human service agency staff.

Public Information Media:

Radio: Public service announcements at beginning of school year on radio stations KQEO, KOB, KRST, and KRKE

Television:

7/77 - KOAT-TV, Channel 7, Focus Program did a feature on teenage pregnancy and New Futures School

3/78 - Channel 23 on New Futures - Barr, Monserrat

4/78 - KOB-TV ran a news feature on New Futures

4/78 - KGGM-TV - Jean Whalen's program - Barr, Monserrat

6/78 - KOAT-TV, KOB-TV, and KGGM-TV - All carried special features on DHEW Secretary Joseph Califano's reference to New Futures School in his testimony before the U.S. Senate Human Resources Committee.

Newspapers and Periodicals:

7/77 - Albuquerque Tribune ran a feature story on New Futures and the problems of NFS students with babysitting to allow continued education.

7/77 - The Sandia Labs newspaper ran a feature story on N.F.S.

9/77 - Albuquerque Journal feature article on "Sweet Sixteen" included a former NFS student and information on NFS.

10/77 - Seers Catalogue carried a feature story on NFS

10/77 - APS Staff Newsletter carried an item about NFS

10/77 - New Mexico School Review convention issue had an article on NFS

11/77 - Albuquerque Journal article on teenage program included NFS

12/77 - An article on NFS appeared in "The Informer"

12/77 - Seer's Catalogue had article on NFS

1/78 - NFS was mentioned in an article in Albuquerque Journal on sex education

2/78 - Albuquerque Journal ran a feature article on "Teenage Pregnancy: A New Beginning"

5/78 - A new parenting directory published by the National PTA and National Foundation, March-of-Dimes, included a description of N.F.S.

6/78 - Albuquerque Tribune ran a front-page story on NFS

6/78 - Albuquerque Journal ran story on N.F.S.

Conference Leadership:

8/77 - March of Dimes Youth Conference: Protomastro spoke on N.F.S. and teenage pregnancy

9/77 - International Childbirth Education Association - Western Regional Conference: Barr, Monserrat workshop leaders; panel of students "N.F.S."

9/77 - New Mexico Family Planning Council statewide training workshop: Gaston, Barr, Monserrat, Protomastro, Panel of former students

9/77 - ICEA Conference workshop "Tuning in to Twins": Berg. Berg also was coordinator for film showings. Barr, Monserrat: workshop.

9/77 - NAACOG: Barr & Monserrat 'spread the word' about N.F.S. and were invited to submit abstract and give presentation next year

10/77 - Denver Conference on Working with Single Parents: Protomastro, two workshops

10/77 - HEW Planned Parenthood Conference on Adolescent Pregnancy - Strategies for Community Action: Gaston - General session speech on the economic and vocational implications of teenage pregnancy - also slide/tape presentation

10/77 - 3rd Annual NACSAP National Conference: Gaston made general session presentation on NFS funding and program - two workshops on staff training

10/77 - NEA - New Mexico State Convention: Barr, Monserrat - two workshops

2/78 - National Parenting Institute, Delaware: Gaston - workshop and exhibit

3/78 - State FHA conference - 4 workshops: Sisneros, Johnson - slide/tape presentation

3/78 - Parenting Materials Conference - exhibit: Barr, Monserrat

4/78 - Texas Family Planning Association State Conference: Gaston - two workshops - "Services to Teens"

4/78 - NAACOG Meeting at El Paso: Barr, Monserrat - Display and explanation of new book

4/78 - Bernalillo County Council of PTA: Barr, Monserrat

4/78 - La Clinica del Pueblo (Tierra Amarilla staff): Barr, Monserrat

5/78 - Isleta Pueblo Community Health Fair: Johnson - exhibit

6/78 - March of Dimes Parenting Priority Conference: Barr, Monserrat and Panel of former students

6/78 - American Home Economics Association National Convention: Monserrat - display of books

Staff attending conferences:

9/77 - Johnson - New Mexico Family Planning - Adolescent Sexuality

9/77 - Sisneros - Hogares - Family Counseling

9/77 - Barr, Monserrat - NAACOG - Nurses Association, American College of Obstetrics and Gynecologists

10/77 - CGAP meeting on legal rights of teens - Counselors

10/77 - 3rd Annual National Conference of NACSAP - 4 staff

4/78 - Farrell - State Home Economics Conference

5/78 - Farrell - Parenting Conference sponsored by U.S. Office of Education and The Childrens Bureau

Special Events for the Year:

A statistical study on New Futures School 1972-1977 was completed.

Former NFS students (plus a few who were not) enrolled in Freedom High's home-study program attended a one-hour rap session each week at New Futures. This will continue in the future.

A new edition of "I'm Not Bad, Just Pregnant" was completed and is now in use.

Counselors completed a workbook for use in their special two-week program in Family Living.

W.O.R.P. (a student work-study program) is now at New Futures School.

A Career Day was held on January 19, 1978.

Karen Zuzich-Cangino conducted an in-service day for staff on "The Counselor's Approach to Sexuality."

Two staff members from Tucson spent two days of observation, training and technical assistance at NFS.

Toni Berg was elected to Sigma Theta Tau, national honorary nursing association.

NFS served as a field placement site for a UNM Master's Practicum student in Counseling and Guidance.

UNM senior home ec student did field work at NFS.

Toni Berg began a study on breastfeeding.

The Opti-Mrs. Club had a regular monthly meeting at NFS, ate with staff and toured facilities.

The four staff attending NACSAP conference had personal conversations with all four members of New Mexico's congressional delegation.

It was decided to move N.F.S. to Monroe Junior High building.

Sixteen students volunteered to march for the March of Dimes.

A textbook, Teenage Pregnancy: A New Beginning, was published. Supplementary materials include a pre and post test, a teacher's manual, and a student study guide. A two-day training workshop for staff members of the testing sites in Farmington and El Paso who will use text was held. Dr. Jose Fuentes spoke to one session.

DHEW Secretary Joseph Califano selected NFS as one of four model programs for adolescent parents in the United States.

Forty-eight seniors participated in NFS Graduation on May 25th. The Pilot Club of Albuquerque sponsored the reception for 700 guests.

The 4th Annual Luncheon of New Futures, Inc. was held on April 27th. Guests heard panel of former NFS students.

Students' Special Activities:

10/78 - Halloween Party

11/78 - Thanksgiving Day Dinner

12/78 - Christmas Dinner

2/78 - Valentine Party

3/78 - All-school picnic at Roosevelt Park

5/78 - Posole fund-raising dinner - $300+

5/78 - All-school swimming party and picnic at Mountainside YMCA

5/78 - All-school field trip to Santa Fe with funds provided by Opti-Mrs. Club.

6/78 - Summer school puppet show

N.F.S. Makes the News:

8/77 - NFS was one of two school-age parent programs described in DHEW regional conference in Chicago as model programs identified by the Child Welfare Resource Information Exchange (within Childrens Bureau of HEW).

11/77 - NFS was discussed as an exemplary program at the West Coast regional Child Welfare Resource Information Exchange Conference.

1/78 - A description of the parenting and child development components of NFS was included as a model in a questionnaire mailed nationally by a researcher at the National Institute of Mental Health.

3/78 - Two witnesses for the House Select Committee on Population - Mr. Sargent Shriver and Ms. Marjorie Mecklenberg, President of American Citizens Concerned with Life - made mention of NFS in their testimony regarding adolescent pregnancy.

5/78 - A new parenting directory published by the National PTA and the National Foundation March of Dimes includes description of NFS.

6/78 - DHEW Secretary Joseph Califano referred to NFS in his testimony before the U.S. Senate Human Resources Committee.

6/78 - DHEW Secretary Califano identified NFS as one of four model programs for school-age parents.

Mrs. Gaston - Special Events:

7/77 - Attended meeting of DHEW work group on adolescent pregnancy in Washington D.C.

7/77 - Appointed to DHEW Region VI task force on child development

8/77 - Participated in DHEW-sponsored colloquium on training for personnel working with adolescent parents.

10/77 - Taped 4-5 hour interview for Mitre Corporation of McLean, Virginia to be basis of article in booklet on model parenting programs.

10/77 - Met with Ms. Launa Miller, Assistant to the Secretary, DHEW, to discuss NFS and developing comprehensive programs for teen-age parents.

10/77 - Spoke with Kennedy Foundation staff member Dr. Herb Kramer about NFS. Also spoke with Mrs. Shriver.

12/77 - Invited to consult with Kennedy Foundation and make recommendations on teenage pregnancy.

3/78 - Discussed NFS and services to adolescent parents with Mr. Gerald Britten, leader of HEW's Adolescent Pregnancy Initiative and two of his staff.

3/78 - Spoke with the following: Mrs. Eunice Shriver; Bob Montague, Chief for Kennedy Foundation; five staff of U.S. Office of Education, Special Programs Office; Senator Pete Domenici; Dollie Wolverton, Head of Childrens Bureau; Ernie Peterson of HEW's Family Planning Bureau; Dr. Marion Howard of Emory University and Grady Hospital in Atlanta.

4/78 - Appointed to Advisory Committee to New Mexico Health Systems Agency.

4/78 - Represented Project Directors of the New Mexico Family Planning Council before two review groups of New Mexico Health Systems Agency.

4/78 - Re-elected Treasurer of Board of New Mexico Family Planning Council.

5/78 - Spent twelve days in Washington D.C. as consultant to The Kennedy Foundation in support of bill S.2910, speaking with senators and representatives and working closely with Dr. Lula Mae Mix, newly appointed Coordinator of DHEW's Adolescent Pregnancy Initiative.

6/78 - Gave testimony before United States Senate Human Resources Committee, which was carried on local educational television.

Other New Mexico Residents: 25 (9.7%)

Cuba	1
Quemado	1
Penasco	1
Questa	1
Taos	1
Gallup	2
Santa Fe	1
Clovis	1
Wagon Mound	2
Farmington	2
Los Alamos	1
Springer	1
Carlsbad	2
Roy	1
Roswell	4
Mountainaire	1
Espanola	2

Other States: 22 (8.6%)

Iowa	1
Wyoming	2
Louisiana	1
California	6
Kentucky	1
Alabama	1
Texas	7
New York	1
Arizona	1
South Carolina	1